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VETERANS' ADMINISTRATION FISCAL YEAR 1986 BUDGET

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

NINETY-NINTH CONGRESS

FIRST SESSION

FEBRUARY 20, 1985

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VETERANS' ADMINISTRATION FISCAL YEAR 1986 BUDGET

WEDNESDAY, FEBRUARY 20, 1985

U.S. Senate,
Committee on Veterans' Affairs,
Washington, DC.

The committee met, pursuant to notice, at 1:10 p.m., in room SR-418, Russell Senate Office Building, Hon. Frank H. Murkowski (chairman of the committee), presiding.

Present: Chairman Frank H. Murkowski, Senators Alan K. Simpson, Strom Thurmond, Arlen Specter, Jeremiah Denton, Alan Cranston, Spark M. Matsunaga, Dennis DeConcini, and George J. Mitchell.

OPENING STATEMENT OF HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Chairman Murkowski. The Senate Veterans' Affairs Committee hearing on the Veterans' Administration Budget for Fiscal Year 1986 is called to order. I am going to ask Senator Strom Thurmond, who is conducting extensive Judiciary Committee hearings today on the Meese nomination which he must return to, to make his statement at this time.

Senator Thurmond. Thank you very much.

Mr. Chairman, it is a pleasure to be here today to receive testimony on the Veterans' Administration proposed budget for fiscal year 1986. I am especially pleased to welcome Senator Murkowski as he assumes the position of chairman of the Senate Committee on Veterans' Affairs.

Mr. Chairman, this committee has a great responsibility to all of our Nation's veterans, and I am confident that you will serve ably in your new position, and I shall be pleased to cooperate with you in every way that I can. I look forward to working with you.

I wish to welcome the Administrator of Veterans' Affairs, Mr. Harry N. Walters, and Deputy Assistant Secretary of Labor for Veterans' Employment and Training, Mr. Donald J. Shasteen, and other officials of the Veterans' Administration and the Department of Labor who are appearing today to testify on the budgets pertaining to veterans' benefits and services.

Mr. Walters, Mr. Shasteen, and their staffs are to be commended for the fine jobs which they are doing in serving the Nation's veterans.

Mr. Chairman, it is also a pleasure to welcome Mr. Chad Colley, national commander of the Disabled American Veterans; Mr.

Donald H. Schwab of the Veterans of Foreign Wars; Mr. Paul Egan and Mr. John Sommer of The American Legion; Mr. David Passamaneck of the AMVETS; Mr. Jack Powell of the Paralyzed Veterans of America; and Mr. Dennis Rhoades of the Vietnam Veterans of America.

Mr. Chairman, the administration's proposed fiscal year 1986 budget for the Veterans' Administration requests $27.1 billion in budget authority. This amount represents a decrease of $123.5 million from the fiscal year 1985 budget request.

To achieve this decrease in expenditures, the administration's budget proposes several actions, including a 5-percent reduction in pay for VA employees, implementation of third party reimbursements for medical insurance coverage, an increase in the loan origination fee on VA guaranteed home loans from 1 percent to 5 percent, and a $156.4 million reduction in construction funding.

In view of the necessity to reduce the soaring Federal budget deficit, this committee faces a difficult challenge of weighing competing demands for limited resources. It is therefore most important that the budget proposals made by the administration be carefully scrutinized to ensure that the Nation's commitment to our deserving veterans is met through the provision of adequate benefits and services.

I look forward to reading the testimony from this hearing that we will receive today, and to carefully review the proposed funding for the very important veterans' programs administered by the Veterans' Administration and the Department of Labor.

Mr. Chairman, I thank you for calling on me in the beginning as I am handling the nomination of Mr. Ed Meese to be Attorney General of the United States, and I need to get back to the Senate floor. Thank you very much.

Chairman MURKOWSKI. Thank you very much, Senator Thurmond. We appreciate your statement very much. I also want to thank you for your continued support. You were really the father of the Senate Veterans' Affairs Committee on the Republican side, and thanks again. We wish you well as you conduct your very important hearings.

Senator THURMOND. Thank you very much.

Chairman MURKOWSKI. I would like to take this opportunity to welcome you to the Senate Committee on Veterans' Affairs hearing on the proposed fiscal year 1986 budget for the Veterans' Administration and the Department of Labor's Veterans' Employment and Training Programs.

Mt. Suribachi I think remains vivid in the minds of many of you who are in this room today. Forty years ago today, the marines landed on some 2 miles of very barren beach on Iwo Jima. We lost approximately 6,800 men, and the enemy lost approximately 20,000. I would like to ask for a moment of silence in memory of those who gave their supreme sacrifice 40 years ago today. [Moment of silence.]

Ladies and gentlemen, I am honored to have the opportunity to serve as chairman of this committee, and I welcome the great responsibility to serve all of the veterans of our country. I am looking forward to working with all of you, and in particular, Senator

Cranston, ranking minority member, and all of my distinguished colleagues on the committee and their staffs.

I am advised that Senator Denton is chairing the Senate at this time, and he intends to be with us as soon as that is completed.

I want to extend a warm welcome to Harry Walters and his fine team at the Veterans' Administration, to Don Shasteen and his colleagues at the Department of Labor, and to all of the service organizations represented, who add such an important perspective to our oversight responsibilities concerning veterans' programs and services.

I recognize that I assume this responsibility as a result of the seniority system and have moved through the ranks with the swiftness of lightning. I accept the challenge and I look ahead to the contribution which I can make.

The days and months ahead are going to be long and difficult as we attempt to restore fiscal responsibility to Government. The course is going to be difficult, in part, because every aspect of Federal spending is being carefully scrutinized, and the competing demands for limited resources will grow more intense.

We are in this situation as a consequence of deficits which have caused the administration's budget proposal to reflect specific cuts. The fact that we have accumulated or amassed a total debt in excess of $1.6 trillion would ordinarily speak for itself. However, the interest on that debt amounts to 18 cents out of every dollar that the Federal Government currently outlays. I think that fact sets it in an appropriate perspective.

As a consequence, it is estimated that if budget cuts are not made, next year's interest will approach the anticipated deficit for the year. The significance of that is—the interest provides no new programs nor does it provide any jobs in this country.

It is all the more important that we work together, and I emphasize together, to ensure that benefits for those who have borne the battle and their survivors are protected, and you know what is needed better than I.

In the near future, I intend to introduce a comprehensive legislative proposal which will touch upon various aspects of the VA's benefits and services. I would like to take just a moment to touch upon one portion of that legislation which would establish, hopefully, a pilot program to target the special needs of Vietnam veterans who continue to have readjustment problems associated with their rehabilitation.

Certainly, the Vet Centers play an important part in bridging the gap between the Vietnam veteran and the agency charged with their readjustment into civilian life. I know that program has been very successful in my State.

The program is a community-based effort where the veterans who reside either in rural or urban areas can go for one-on-one counseling and assistance. In my view, however, Vet Centers lack certain professional resources necessary to function as effectively as they could.

The proposed program would establish a certain number of Vietnam Veterans' Resource Centers [VVRC's], the Government's coinage of the vernacular, in existing Vet Center space.

The needs of Vietnam veterans reflect the living, changing world that they are striving to cope with. These needs necessarily change with time and circumstances. We must recognize that psychological readjustment, education, drug and alcohol counseling, and employment training are not exclusive of one another, but are all a part of re-establishing certain veterans as confident and productive members of our society.

This proposal would help establish, in one location, a number of services that those veterans may need to reach that goal. And these services would include a continuation of the readjustment counseling program. In addition, employment training and job placement, alcohol and drug counseling, and education and rehabilitation services would be added by providing trained specialists in the individual setting.

The proposed VVRC sites would be placed throughout the country in both urban and rural areas. And a report would be due after 2 years of the pilot program to determine if the approach should be adopted nationwide.

Vet Centers currently include some of the services I have mentioned. However, restoration and readjustment counseling is mandated, and trained specialists from the Department of Labor or the VA's Department of Veterans' Benefits are not generally an integral part of the Vet Center services.

I believe that it is important to establish our priorities and to focus our resources in areas where the greatest rehabilitation is possible. I also believe strongly that an investment in our Vietnam veterans to return them to a feeling of self-esteem and self-sufficiency is an investment that will be paid back to this country many times over.

The President's budget for fiscal year 1986 for the Veterans' Administration requests $27.1 billion in budget authority in order to deliver the VA's broad range of programs and services to our Nation's veterans.

The administration has clearly stated its firm commitment to reduce the Federal budget deficit which, as I have already mentioned, has been increasing at a very alarming rate. Regaining responsible fiscal control of the Federal budget is inherent in the goal.

In keeping with this plan, the President's fiscal year 1986 budget requests funding for the VA at the 1985 fiscal year level. Policy changes which would result in additional budget savings have been proposed as well. These include a proposal to increase the home loan guaranty program origination fee from 1 percent to 5 percent. I think that there are some other problems associated with that home loan program, such as the 20,000 to 33,000 foreclosures. That area deserves some examination and perhaps different medicine.

Another provision provides for a 5-percent pay reduction for all Federal employees. Obviously, that is getting some attention around Washington and I expect it will get your attention too during your testimony. Other provisions would establish a means test for VA medical care eligibility, allow for third-party reimbursement for medical care, slow down funding for VA construction, and consolidate certain services in the Department of Veterans Benefits.

Of course, I expect your testimony to reflect your opinion and your representation of the various organizations which you represent. But in order for the committee to make sound, meaningful, and timely recommendations to the Budget Committee, I genuinely and sincerely request your views on the administration's major policy changes which would achieve the projected budget savings.

No one wishes to applaud cutbacks or savings. However, some programs that we have had over the years are no longer relevant to the changing needs of our veterans. I think that it is the responsibility of this committee, which formerly had been under the outstanding leadership of our new majority whip, Senator Alan Simpson, who has just joined us, to analyze the needs of today's veterans in relationship to the programs which are currently in effect. That way we can make decisions regarding areas which should be enhanced, altered, or perhaps eliminated to meet these changing needs.

I think that we would all agree that veterans' needs are living needs, and they change as the age of the veteran changes. No one wishes to spend money for programs or facilities which no longer meet the goals and objectives of the Veterans' Administration.

I earnestly welcome your suggestions on how the committee can achieve cost savings in the most efficient and equitable manner, with the least disruption to existing medical and benefit programs.

At this time, I want to acknowledge the presence of a distinguished colleague and the committee's ranking minority member, Senator Alan Cranston. Also, I have introduced Senator Alan Simpson, who just joined us. Senator Mitchell has been here since the opening of the committee hearing and we have just been joined by Senator DeConcini.

According to the seniority schedule, Senator Simpson is the senior member in spite of the fact that Senator Cranston has been here longer.

Senator SIMPSON. I learned never to do that.

Chairman MURKOWSKI. I see. Well, you have been at it longer than I have.

Senator SIMPSON. I tell you, Al, if I might just say a word, and I will be on my way.

Chairman MURKOWSKI. Sure.

Senator SIMPSON. I want to pay special tribute to you, Frank, as you embark on these new duties. It was a great thrill, and I mean that, and an honor and a privilege to serve as chairman of this committee. Senator Cranston and I fixed up this room, and now you have taken it over.

Chairman MURKOWSKI. We will take good care of it.

Senator SIMPSON. I know you will. I just want to say that one of my great pleasures in the course of this was working with Al Cranston and with that very special staff of the majority and the minority. And I see that many of them are here—Tony Principi, and Julie, Jon, Ed, Babette, so many capable people. It is good to see you using those bright people.

But I owe you special appreciation for the marvelous ease of this transition. There was even a little pain involved. I hate to leave this chairmanship, but I assure you that I will participate as a member of this committee as I have in the past.

And I thank you for your courtesies extended to me, Frank. I wish you well. I would just say to you that you will learn as I did to deal with the veterans' groups. They were very patient and tolerant of me after some rocky first times. It was, as they say, a psychological learning experience. It was not always fun. But I learned to confide in them, and to accept their counsel, and to work with Harry Walters and Ev Alvarez. I look forward to working with Dr. Ditzler. I admire what he is trying to do.

We have some serious stuff to be doing. There are 30 million veterans in the United States and I am one. I think that we ought to disabuse ourselves that somehow veterans in this country are disadvantaged. That offends me. And there is enough talk about that to think that all 30 million of them somehow are disadvantaged in America. That is a bunch of garbage.

We have got some serious issues, and we want to deal honestly with them, the Vietnam veteran and his special needs, and let's get on with it. But for heaven's sake, let's not look upon ourselves as some lesser part of society.

How did we ever get to that point? I do not know, but I sure do not like it, and we do not have to go for it. So Harry, good luck to you; Ev, and all of you. And to Frank, God bless you. You will need all of the strength that you can muster.

Chairman MURKOWSKI. Thank you, my friend.

Senator SIMPSON. And Al, good luck to you too with Frank.

Senator CRANSTON. Thank you.

Chairman MURKOWSKI. Thank you very much, Al. I appreciate those kind words. Before I ask Senator Cranston to open with his remarks, I would also like to indicate to you that in addition to the testimony to be given by the Administrator, Harry Walters, we also have requested written testimony from the Veterans' Administration's inspector general, Frank Sato.

I want to acknowledge publicly the importance of the independence of the inspector general of the agency. Sometimes that becomes blurred, I am told, due to the funding requests that go to OMB as a package. We do very much depend on independent audits and investigation. The committee will evaluate the inspector general's budget separately, taking into consideration the unique mission of that office. Frank, we are pleased to have you at the hearing today.

Now I would welcome Senator Cranston's statement.

It's certainly an honor, Senator Cranston, after the many years of your tenure on the Veterans' Committee—you and Senator Jennings Randolph—to be with you here in this capacity. I look forward to your advice and counsel, my friend, and I welcome your opening statement.

Senator CRANSTON. Thank you very much, Frank. I appreciate those generous words.

This is my first opportunity to formally congratulate you on your assuming the chairmanship of this committee. I'm delighted that you have, although it was great to work with Al Simpson while he was the chairman. And I know that he and I will continue to work together on this committee and in our mutual roles as whips on our respective sides of the aisle.

We've built a strong tradition of bipartisan cooperation on this committee, and I want to assure you, Frank, that I will continue, in the days ahead, to help you maintain that tradition.

I believe very strongly that we are best able to serve both the Nation's veterans and the Nation's taxpayers when we act in a unified way.

I join Frank in welcoming all the rest of you to this hearing.

I want to congratulate and welcome here today the VA's new chief medical director, Dr. John Ditzler.

I'm delighted that you are now in that role and you are present today.

I've admired Dr. Ditzler's work since he was in the VA's central office in the late 1970's and, more recently, in his service as the director of the San Diego VA Medical Center.

I welcome you and look forward to working with you in your new capacity.

Regarding the matter before us today, the VA's budget, I support fully the proposal to provide for service-connected disability compensation and DIC recipients the same COLA that is projected for Social Security recipients.

In the same vein, I am pleased that there is no proposal to deny the scheduled December 1, 1985, COLA to non-service-connected pension recipients.

So much for the good news.

I do have some serious concerns about various other major thrusts set forth in this budget.

I know that most of today's witnesses share these concerns.

I am eager to explore how we can best deal with them while, at the same time, meeting our responsibilities to participate in the much-needed effort to take all reasonable and appropriate actions to reduce the enormous projected Federal deficits.

My primary areas of concern about the VA's fiscal year 1986 budget are as follows:

First, the proposal to increase from 1 to 5 percent the VA loan guaranty user fee appears to have the potential for negating the value of the loan guaranty program for vast numbers of veterans and making it impossible for them to acquire homes.

Among veterans of wartime service, the burden of the higher fee would fall disproportionately heavily on Vietnam-era veterans who are likely to be in the market for their first homes and to be in most need of the assistance that the guaranty provides.

Although I will help pursue reasonable measures to shore up the loan guaranty revolving fund, I cannot support the fee increase proposed by the administration.

Second, it appears clear to me that the proposal to consolidate the Department of Veterans' Benefits Regional Offices by transferring most functions out of the existing 58 offices into 3 large centers is, at best, a half-baked concept. It could effectively deprive of basic due process many veterans seeking compensation, pension, GI bill, vocational rehabilitation, loan guaranty, or other benefits administered by DVB.

Also, as I stated in a February 8 letter to the Administrator, I do not believe that, under section 210(b)(2) of title 38, the VA can lawfully take any action to implement this reorganization during fiscal year 1985 or fiscal year 1986. This is because the VA has not yet provided the "detailed plan and justification" for it that the law requires be submitted by the time the President submits the budget for the fiscal year in which the reorganization is to be initiated.

Third, from what I have seen of the proposal for a means test to restrict eligibility for certain non-service-connected disabled veterans—combined with the proposal to eliminate VA health-care eligibility based on being over age 65—the type of spend-down means test being proposed could result in the VA turning away many sick veterans who are actually unable to afford the care that they need and who would be today cared for.

In addition, this means test could become a bureaucratic nightmare that would ensnarl sick and disabled veterans in an overly complicated procedure superimposed on the admissions process. It also threatens to consume massive amounts of VA personnel time that would be far better spent in providing care.

I'm mystified that an administration that says its goal is to cut Federal paperwork is here proposing to spin a web of redtape around thousands of sick veterans.

Fourth, OMB has used several arbitrary devices to mask some very significant reductions in health-care personnel positions and funding for them. These devices include not using, in the current fiscal year, all of the FTEE provided by the Congress; the forced, arbitrary reduction in the numbers of GS–11 to GS–15 slots; and the 1 percent so-called productivity increase.

At the heart of these actions is OMB's aim to impose arbitrary reductions in the numbers of VA health-care staff providing direct health-care services to veteran patients.

Particularly offensive is the sharp reduction being proposed in the number of staff positions for medical programs in fiscal year 1985 and fiscal year 1986. Congress appropriated funds for 193,941 FTEE under the VA's medical care account for fiscal year 1985. Under this administration's budget, the VA now proposes to use 2,092 less FTEE than were provided for. This ostensibly voluntary DM&S plan to use less staff than has been provided is a first in my experience.

I wonder if this is a plan that has been secretly imposed by OMB, which is required by law to authorize the VA to hire all the staff for which Congress appropriated funding.

For fiscal year 1986, after deducting the staff positions for new activations, the VA's request is for only 189,980. That's a drop of 4,000 from what Congress has provided for essentially the same VA Health-Care Program level in fiscal year 1985. Such personnel reductions threaten to bleed the overall system to the point where its capacity to provide quality health care for eligible veterans is substantially reduced.

I also strongly oppose the proposed across-the-board 5-percent reduction in Federal employees' pay. That reduction is not warranted, and I don't believe Congress will inflict it. Thus, in my opinion, the reductions in various VA accounts attributable to the proposed pay cut should be restored.

Finally, a philosophical note: I am deeply concerned that the various elements of the annual pull and tug of the budget process on the VA health-care system are becoming unduly disruptive and antithetical to any attempt to develop and implement sound health-care strategies for the future.

The current budget proposals for the DM&S is just the latest manifestation of this incapacity to look beyond the current fiscal year and to plan for the future. We need to try to find a better way to do the job. The time is now ripe for a consensus among all the major parties that would lead to stability and a far more effective use of available resources for the VA health-care system.

I want to note that the VA's former Chief Medical Director, Dr. Donald Custis, is, at my request, submitting testimony for the record of today's hearing. Copies are available on the press table.

Dr. Custis' perspective should be particularly useful to the committee as we seek to develop our views on estimates of the agency's fiscal year 1986 budget.

The administration's budget request for the VA presents a number of major problems that will take a lot of hard work to resolve satisfactorily.

I appreciate the participation of all of our witnesses and look forward to working with them, with the new chairman, and the other members of the committee in achieving a fair and equitable result.

Thank you very much, Mr. Chairman.

Chairman MURKOWSKI. Thank you very much, Senator Cranston.

We have been joined by Senator Specter. We acknowledge your presence and look forward to your opening statement after we've gone through the others.

Senator Mitchell, you are next on the roster.

Please proceed.

Senator MITCHELL. Thank you very much, Mr. Chairman.

I want to join the other Senators in congratulating you and to wish you the very best of luck as you assume the chairmanship of this committee.

As Senators Cranston and Simpson have already probably told you, it's a very challenging task. We're confident that you will meet it.

So, we look forward to working with you on the important issues that face this committee, especially on the question of health-care delivery to the Nation's veterans who live in rural areas, which, of course, occurs very widely in both of our States.

I join with the other members of this committee in welcoming Mr. Walters and the other witnesses to today's hearing on the fiscal year's budget for the VA: Witnesses from the VA, the Department of Labor, and the veterans' service organizations.

I apologize in advance that I will not be able to stay for the hearing this afternoon since I will be participating on the floor in the same debate that Senator Thurmond is involved in. I will be leaving shortly to join him in that debate, but I will review all of the prepared testimony very carefully.

For the fiscal year 1986, the President proposes for the VA budget authority of $27.1 billion, which is down $123.5 million from this present fiscal year, and outlays of $26.7 billion, which is a decrease of $82 million from present levels.

All of that goes to provide for the services and benefits which the Congress has enacted for this Nation's nearly 30 million veterans and their 55.5 million family members and survivors.

From this hearing today, from the witnesses and their testimony, I hope to learn how the VA can continue to meet this obligation to America's veterans under the spending levels in the proposed budget.

And I hope the witnesses will deal with that subject, as I expect they will.

Along with the projections, estimates, and dollar figures, the budget contains the outlines of legislative initiatives on veterans' programs and benefits which the VA claims to pursue in fiscal year 1986.

I'm concerned about some of these, including the proposal to limit eligibility for medical care for certain veterans, regardless of age, with incomes above a predetermined standard; the proposal to reduce the level of full-time and permanent employees in the VA's medical facilities; and the proposal to consolidate benefit and claim proceedings and support activities into three regional offices.

I look forward to the comments of today's witnesses on these and other subjects.

Mr. Chairman, I ask your permission to submit a series of questions in writing, since I cannot remain for the hearing. I look forward to receiving replies to those questions at the earliest convenience of the witnesses.

Chairman MURKOWSKI. Senator Mitchell, we would be pleased to receive your statement and any questions you have in writing.

Senator MITCHELL. Thank you, Mr. Chairman.

Chairman MURKOWSKI. We understand your pressing need to return to the Judiciary Committee.

Next in the order of presence is Senator Specter, who I gather is having a little difficulty with his microphone.

Senator SPECTER. Mr. Chairman, I think this microphone works fine.

Chairman MURKOWSKI. Fine. You have the floor.

Senator SPECTER. Mr. Chairman, I am delighted to congratulate you on your taking over as chairman of this committee.

I think that there are two firsts for Senator Murkowski. He is the first Senator from Alaska to be the chairman of the full committee, and he is the first member of the class of 1980 to be the chairman of a full committee.

And speaking from one who is next in line in seniority on the Veterans' Affairs Committee, alphabetically, I have special congratulations to you, Senator Murkowski, on taking over this committee.

And I know from my close association with you for more than 4 years now that this committee is fortunate to have your leadership. And I am pleased to continue to work with you on the committee.

Mr. Chairman, I am delighted that you have convened this important hearing regarding the Veterans' Administration's fiscal year 1986 budget. The administration's budget is an important document and sets the stage for debating the issues. But in my judgment, it is only the first chapter in our consideration and the consideration of the full Senate and the entire Congress.

We, in this committee, have the first duty and responsibility, as I see it, to tailor the Veterans' Administration budget to meet the real needs of our veterans.

Now, I have stated on many occasions—and state again strongly today—that unlike other areas of Federal expenditure, that services to veterans are not grants or gifts, that these are obligations and debts which the U.S. Government owes to the men and women who served in the Armed Forces of the United States, frequently at great personal risk and sacrifice.

I am concerned that this committee keep this concept very much in mind throughout this budget process.

Mr. Chairman, my first conscious recollection was with a veteran who was my father, who was a veteran from World War I who went to France as part of the American expeditionary force to make the world safe for democracy.

And I recall vividly the shrapnel which he carried in his legs from 1917 until his dying day. And I recall his great devotion to this country, having not had the benefit to be born here, but having come to this country from Europe and having served in the Army of the United States and having made a very substantial sacrifice.

And it is in that context that I have and continue to look at the veterans' benefits in terms of having been earned and so frequently at the cost of loss of life or limb, with very substantial pain and suffering.

Now, I have some specific concerns, Mr. Chairman, regarding changes in the eligibility rules, and the use of means test, and its ramifications to many veterans, particularly those over 65 years of age.

I am also hopeful of having an opportunity to discuss the inadequate funding level in the fiscal year 1986 budget for the Philadelphia Veterans' Administration Medical Center.

It is my sense that the project is on schedule and ready to receive the entire remaining $110.4 million. And as I understand the priorities among the hospitals in issue, the Philadelpia center really ought to be next, and that is a subject which I will pursue at an appropriate time.

And our distinguished guests today, in written testimony, have raised many important questions regarding the administration's proposals on the VA Home Loan Program's consolidation plans, medical research cuts, and many more.

I respect the expertise and commitments of these veterans and the millions of Americans they represent. And I, for one, and I know this committee, will listen very closely to their statements today.

Mr. Chairman, sacrifices must be made to trim the Federal deficit. That is something we all understand.

But any plan, as I see it, must take into account the special obligations the United States has to its veterans.

A fair budget is a finely tuned budget, not one that indiscriminately imposes a hardship or undue cuts on individuals who have served our country.

Mr. Chairman, I, too, have duties, as a member of the Judiciary Committee, in connection with the pending nomination of Mr. Meese. But I intend to stay as long as I can. And to the extent that I am unable to submit questions orally, I would ask leave to submit questions in writing.

I thank the Chair.

Chairman MURKOWSKI. You certainly may.

I appreciate your kind comments and your reflection on the commitments that this country has made to the American veterans.

And you may be assured that you may submit questions as your schedule dictates.

Thank you.

Our next member is Senator DeConcini.

Senator DeConcini.

Senator DECONCINI. Mr. Chairman, let me make our good wishes for your chairmanship unanimous.

Having worked with you here and in the Energy Committee, I know your amount of work and dedication. And I'm sure you can easily fill the shoes of Senator Simpson.

And I must say, as to Senator Simpson, those shoes are big shoes. He worked so very diligently and conscientiously. Often I had disagreements with him, but he was always so open and fair. And he will be hard to replace. But I know, Mr. Chairman, that you can fill that bill, although it's not going to be easy.

I agree with Senator Cranston that this committee has a bipartisan approach, a nonpartisan approach, and I want to see it continue to do so.

I agree with the other Senators who have expressed a view here today that the veterans are a special part of our governmental obligation. I equate it to the national defense of our Nation. And I feel very strongly that when we see the budget requests that ask for reductions in the veterans' benefit programs, as has been outlined by several members here, particularly Senator Cranston, I find it difficult to think that this committee would approve those requests.

I understand and appreciate Administrator Walters and other members of the Veterans' Administration having to come forward with certain marching orders. But I pledge here to do all I can to restore these suggested reductions, although I will also attempt to maintain an open mind for consideration of any suggestions on improving the delivery service.

But let me make it very clear, Mr. Chairman, that this Senator feels that reducing veterans' benefits and programs is a very poor way to start off the second term of this administration. I think we can do better. I have expressed a number of times that I am prepared to face the veterans in Arizona if, indeed, we are going to be equal in our treatment of reductions or freezing Government expenditures.

Thus far, the budget that's been suggested by the administration does not do that. It singles out a number of different programs, including veterans' benefits, for what I consider substantial reductions.

I look forward, Mr. Chairman, to working with you, Senator Cranston, and the staff, and our other colleagues on this committee, and with Administrator Walters, and his staff to find a way to enhance this budget without tipping it to the extent where we are unfair to other parts of the Government. But I think we should seriously review some of these suggestions of reductions, and I hope that we can work together to restore funding in the critical program areas.

Thank you, Mr. Chairman.

Chairman MURKOWSKI. Thank you very much, Senator DeConcini.

Senator CRANSTON. Mr. Chairman, could I ask a procedural question before we proceed?

Chairman MURKOWSKI. Sure.

Senator CRANSTON. Unfortunately, I have to leave to attend a joint House-Senate leadership meeting. I wanted to hear the testimony and ask some questions, as always; and I wanted to hear the veterans' service organizations representatives.

I just wanted to get your impression of how long this session will go on, because I will endeavor to get back for at least some of it.

Chairman MURKOWSKI. It's scheduled until 4 o'clock, but it will continue until all the witnesses have had an opportunity to conclude their testimony.

Senator CRANSTON. You expect to be here until at least 4 o'clock yourself?

Chairman MURKOWSKI. I will be here.

Senator CRANSTON. Well, I will do my best to get back so that I can do some of the things that I wanted.

Chairman MURKOWSKI. I will guarantee you, Senator, I will be here until it is over.

Senator CRANSTON. Thank you very much.

Chairman MURKOWSKI. Thank you very much, Senator Cranston. I appreciate the statements by the members of the committee.

Senator CRANSTON. Also, I will phone the moment that I am free from the other meeting. If Mr. Walters could remain so that I can ask him a few questions, I would appreciate that. If not, we will submit them in writing. But I will phone the moment that I am headed back.

Chairman MURKOWSKI. Let me check Mr. Walter's schedule.

Senator CRANSTON. Thank you.

Chairman MURKOWSKI. Will your schedule allow you to be with us the balance of the afternoon, or are you committed elsewhere?

Senator CRANSTON. No; it would not be for the balance of the afternoon.

Chairman MURKOWSKI. Well, availability, let's put it that way.

Mr. WALTERS. I hesitate to mention why I have a commitment, but I could not start my car, and I had them tow it away. You know what was wrong with it? The engine was out of gas because of a clogged fuel filter. I will have to pick the car up before 6 this evening.

Senator CRANSTON. Is that in lieu of a limousine?

Mr. WALTERS. That is in lieu of a limousine.

Chairman MURKOWSKI. It is much more appropriate that Senator Cranston asked that obvious question that had to be asked than by the chairman. I am glad that it was asked and we have cleared the air of having any extraordinary vehicle allowance other than minimum gas. That, I assume, he puts in himself.

Is that right?

Mr. WALTERS. That is right, Mr. Chairman.

Chairman MURKOWSKI. Before we hear from this witness, I would like to thank the members of the committee who have made their opening statements and reflected concern on the wide variety of responsibility to America's veterans, as has been evidenced by the programs that are in effect, and the programs that have been administered so ably by the Veterans' Administration.

As we reflect on the consensus within the committee which is forming around the budget, it has been brought to my attention that the last time that we had a tax review or a major comprehensive revision in this country was some time ago. I was advised, also, that the last time that we had a comprehensive review of veterans' programs, needs, and services was, I believe, the Bradley Commission report, which was some time ago.

To put that some time ago into a frame of mind that most of us in this room can refer to, Joe DiMaggio had just wed Marilyn Monroe. So if that reflects on the need to go back and consider some type of a comprehensive review of the changing needs of the veterans within the budget allocations and the specific role that the various veterans organizations provide, why, I think that is worthy of your consideration and recommendation to the committee and myself, as chairman.

I am not asking that you provide a definitive expression of your attitude on that, but, it does appear that something along the lines of a statutory commission might be in order.

I would just alert you to the fact that I would be receptive to any comments or recommendations along those lines, as you are prepared within your organizations to address that matter.

Our first witness, of course, is the Administrator of the Veterans' Administration, Harry Walters.

Harry, the committee operates under a standard procedure of a 5-minute limitation on oral testimony which we occasionally enforce, depending on the call of the Chair, in order to allow sufficient time for questions.

With that profound statement, we will listen attentively to your statement and we welcome you to the committee. I want you and your associates and others in the room to know that I have had a number of meetings with you already and I look forward to continuing our dialog as we mutually move down the path of what is hopefully in the best interests of the veterans of the United States.

Mr. Walters.

TESTIMONY OF HARRY N. WALTERS, ADMINISTRATOR OF VETERANS' AFFAIRS, VETERANS' ADMINISTRATION, ACCOMPANIED BY EVERETT ALVAREZ, JR., DEPUTY ADMINISTRATOR; DR. JOHN W. DITZLER, CHIEF MEDICAL DIRECTOR; JOHN W. HAGAN, ACTING CHIEF BENEFITS DIRECTOR; AND PAUL T. BANNAI, CHIEF MEMORIAL AFFAIRS DIRECTOR

Mr. WALTERS. Thank you, Mr. Chairman.

I have a prepared statement which I would like to enter for the record.

Chairman MURKOWSKI. It will be entered into the record.

Mr. WALTERS. Thank you.

Mr. Chairman and members of the committee, I am grateful for the opportunity to appear before you today to discuss the Veterans' Administration 1986 budget.

When I was confirmed as the Administrator for Veterans' Affairs, I said that I would be the advocate for our Nation's veterans.

In that regard, no budget can adequately repay our veterans for all that they have done for America. However, I, like the veterans that the VA supports, realize that the Nation has a challenge confronting it, the national deficit.

Veterans have always been willing to share in solving America's problems so long as they were treated fairly in comparison to those who did not serve. This year's budget, in my view, does treat veterans fairly in relationship to other Government activities.

I believe this fact shows the importance the President places on veterans and veterans' benefits. This year's budget calls for $27.1 billion in new budget authority, of which, $26.3 billion is the appropriation request; $61.8 million for proposed legislation; and $851 million through permanent authorizations.

The largest portion of the budget request continues to be in our benefits program. Overall a benefits request of $15.6 billion represents over 59 percent of the total request. The benefits program includes proposed legislation for a 4.1-percent rate increase which will be effective December 1, 1985.

For medical care, this budget shows an increase of $236 million over the 1985 level for direct medical care. The employment level for direct medical care is projected to increase by 199 over an adjusted 1985 employment level of 191,849. Workload projections for inpatients treated and outpatient visits show increases over 1985.

The budget contains proposed legislation to eliminate medical care without regard to income levels for those veterans over 65, and to make their eligibility the same as veterans under the age of 65. Exempted from this reform, would be service-connected veterans and certain categories of other veterans. This reform would restrict the use of the medical system by all nonexempt veterans whose income exceeds the eligibility level. I believe this to be important legislation and ask your support in its passage, need not age, should be the critical factor in determining eligibility for nonservice-connected veterans.

Legislation is also proposed to obtain third party reimbursements for the cost of medical care and treatment for veterans with nonservice-connected disabilities. The VA already does this when it can.

Our request for general operating expenses includes $749 million and 18,681 average employment for the operations of the Department of Veterans' Benefits; the Department of Memorial Affairs and the various staff functions of our central office.

The budget states that the VA will consolidate some of DVB's facilities. This may happen. But we cannot tell at this time. An effort to develop a plan for modernizing the entire DVB operations has just begun. The plan will consider several alternatives, including consolidation. When it is completed, a decision can be made as to the best course of action to be taken concerning the Department of Veterans' Benefits.

In the General Administration activity, average employment reductions of 154 FTEE will be achieved through improved productivity and efficiencies in operations and will not reduce services provided.

I propose closing two data processing facilities. Their functions will be consolidated at Hines, IL and Austin, TX. The closure of the St. Paul and Los Angeles data processing centers and the Romney, WV message switching center will reduce average employment by 113.

In the construction appropriation request, $713 million is included for medical facility projects; $18.9 million for the national cemetery program; $2 million for DVB; $2 million for the office of data management and telecommunications; $500,000 for the year-old emergency fund; and $35.3 million for the expenses of the office of construction.

Of the total program request of $771.6 million, $160 million is made available from prior appropriations. Of the 33 major projects, initial construction funding is included for Philadelphia, PA, with funding for the main hospital building for Houston and renovations and replacement of buildings for Mountain Home, TN also requested.

One other point I would like to make is that the out year numbers for medical care in this budget are plugged numbers. They are not meaningful. National policy decisions must yet be reached. These decisions will affect the VA. Discussions leading to these decisions will be conducted in the sunlight, and hopefully will include the Veterans' Administration, the veterans' service organizations and all other interested parties.

This briefly summarizes my opening remarks, Mr. Chairman.

My staff and I, of course, will be pleased to answer your questions regarding the budget.

Chairman MURKOWSKI. Thank you very much, Mr. Walters.

[The prepared statement of Harry N. Walters, Administrator of Veterans' Affairs, Veterans' Administration, follows:]

PREPARED STATEMENT OF HARRY N. WALTERS, ADMINISTRATOR OF VETERANS' AFFAIRS, VETERANS' ADMINISTRATION

Mr. Chairman and Members of the Committee, I am pleased to appear before you today to testify in support of the Veterans Administration's fiscal year 1986 budget. This budget will allow us to continue to serve our Nation's veterans well.

As you know Mr. Chairman, this budget shows an effect of the President's emphasis on reducing the Federal deficit. However, you will find during this review of the budget, that the VA has fared very well in comparison to some other Departments of Government.

The total budget authority request for 1986 is $27.1 billion which consists of an appropriation request of $26.3 billion, $-61.8 million for proposed legislation and an estimate of $851 million through permanent authorizations. Increases in benefits for service-disabled compensation and pension beneficiaries and funding increases in Medical Care are more than offset by the 5 percent reduction in 1986 pay, implementation of third party reimbursements for medical insurance coverage, increased Loan Guaranty fees, and a reduction in construction funding.

Legislation is being proposed to eliminate medical care without regard to income levels for those veterans over 65 and make their eligibility the same as veterans under 65. Exempted from this reform would be service-connected veterans and certain categories of other veterans. This reform would restrict the use of the system by all non-exempt veterans whose income exceeds the eligibility level.

These higher income veterans would not be eligible for VA health care until their out-of-pocket medical expenses exceeded certain amounts. These amounts would be an increasing percentage from 25-90 percent of the amount that the veteran's income exceeded the eligibility level. This eligibility level would be set at twice the VA pension income standard. In emergency and extraordinary circumstances, veterans could receive care in the VA medical system by making their out-of-pocket contributions direct to the VA for the medical care received. In rare and exceptional circumstances, the VA Administrator could waive the veteran's expected medical expense contribution.

We are also planning to build on the mission and goals which the Department Heads and I established shortly after I joined the VA. Agency-wide we are beginning the pursuit of a cost saving ADP and Telecommunications modernization goal as a major element of our management goal. The thrust of that goal will be to provide better service to the veterans through the increased use of modern ADP and telecommunications technologies. I will be sharing with you over the next several months more detailed information about this goal and the objectives that support it.

I will now highlight the VA's request for major accounts.

Compensation

The appropriation request for this account is $10.2 billion. This amount is based on an estimated caseload of 2.2 million veterans which is a slight decrease from 1985 and 335 thousand survivors - a decrease of 4,100 from 1985. A rate increase of 4.1 percent, effective December 1, 1985, at a cost of $342.8 million also is included under proposed legislation. A December 1, 1984 rate increase of $263.4 million is being met primarily with a supplemental appropriation request of $175 million. Lower caseloads in both Compensation and Pensions allow the remaining costs to be met with existing funding.

Pensions

The Pensions caseload will continue to decrease in 1986. Current estimates indicate the veterans caseload will decrease by 34 thousand to 676 thousand while the survivors caseload will decrease by 64 thousand to 711 thousand. However, total budget authority shows an increase of $26.6 million to $3.8 billion due to an anticipated automatic cost-of-living increase of 4.1 percent effective December 1, 1985.

Burial Benefits and Miscellaneous Assistance

A budget authority increase of $2.8 million to $136.8 million is requested. This increase reflects the higher mortality rate of the aging veteran population.

Readjustment Benefits

An appropriation in excess of $1 billion is requested for 1986. This request, a decrease of $156 million from the 1985 request, shows the continued decrease of trainees as more veterans pass their 10 year delimiting date or attain their educational objectives. A 1985 supplemental appropriation of $44.2 million is requested to fund the 10 percent rate increase effective October 1, 1984.

Loan Guaranty

This request includes $404.6 million to help fund obligations of $1.91 billion. Estimated obligations for 1986 are $419 million less than the 1985 estimate. The Deficit Reduction Act of 1984 requires the VA to acquire properties under certain conditions. This Act also raised the 1/2 percent loan origination fee to a one percent loan origination fee on all loans. Revenue from this loan origination fee is to be deposited into the Loan Guaranty Revolving Fund to offset required obligations.

The Administration will request, under proposed legislation, an increase in this loan origination fee from the current one percent to five percent on both guaranteed and vendee (direct) loans. The vendee (direct) loan purchaser will have the option of paying the five percent loan origination fee or a one percent loan origination fee and a minimum of 5 percent down payment with a purchase of private mortgage insurance. If these initiatives are converted into public law, the fees will preclude the need for the $404.6 million budget authority request. This request clearly reflects the Administration's policy to require those receiving federal loan guarantees to pay for part or all of the expected federal default liability on the guaranteed loans.

Legislation also will be proposed to repeal the current authority to establish the maximum interest rate and instead allow negotiated rates between borrowers and lenders.

General Operating Expenses

The budget request for General Operating Expenses is $749 million and 18,681 average employment for the operations of the Department of Veterans Benefits, the Department of Memorial Affairs, and the various staff functions of our Central Office.

On February 11, 1985 a meeting was held between the VA Administrator and the Deputy OMB Director. At that time it was agreed that VA would develop a plan for modernizing its entire operations and will be considering various efficiency alternatives, one of which will be DVB consolidation. This effort has just begun and, when it is completed, a decision will be made as to the best course of action to be taken concerning DVB.

The Department of Memorial Affairs shows a request of 1,161 FTEE which is a reduction of 57 below the 1985 level. This reduction will be achieved by contracting various activities at national cemeteries. It is expected that total interments will increase by 6 percent, gravesites maintained will increase by 2.5 percent, and headstone/marker applications processed will be 2.7 percent over 1985 levels.

In the General Administration activity, 1986 funding and FTEE will be reduced below the 1985 estimates by $680,000 and 154 FTEE, respectively. The FTEE reductions will be achieved through improved productivity and efficiencies in operations which will not reduce services provided. To assist in this effort, $2 million is included for office automation which is expected to yield productivity improvements in 1986 and the future. Within the data processing activity, several facilities will close with those functions consolidated at the primary data processing centers in Hines, Illinois and Austin, Texas. The closure of the St. Paul and Los Angeles data processing centers, and the Romney, West Virginia message switching center will result in average employment requirements being reduced by 113.

Medical Care

The Medical Care appropriation request for 1986 is $9.1 billion, an increase of $235.6 million over the 1985 level. Average employment is projected to increase by 199 over an adjusted 1985 employment level of 191,849. The number of inpatients treated is projected to increase by 3,211 to a level of 1.4 million, and outpatient medical visits will increase by 112 thousand to a level of 18.8 million. The increased resources also will provide partial year activation resources for the replacement hospital at Portland, Oregon, replacement and modernization of clinical services at Albuquerque, New Mexico, and expansion of clinical, outpatient and administrative facilities at Birmingham, Alabama. One new satellite outpatient clinic will be activated.

The 1986 request also provides for new or expanded initiatives in the areas of: the Integrated Hospital System, Occupational Safety and Health program and a physical fitness program for the disabled/handicapped.

In addition, legislation will be proposed to obtain reimbursement from third party insurance carriers for the cost of medical care and treatment to non-service-connected veterans.

MEDICAL AND PROSTHETIC RESEARCH

The 1986 total request for Medical and Prosthetic Research of $187.1 million and 4,348 FTEE. The 1986 requirements for the Agent Orange Epidemiology Study being conducted by the Centers for Disease Control is $3.8 million. Research support will continue in the ongoing high priority research programs in Agent Orange, aging, health of former Prisoners of Wars, alcoholism, health problems of female veterans, spinal cord injury, delayed stress disorders, cancer, preventive health, and prosthetic/sensory aids. Because of their high priority, no FTEE reduction is planned for Prosthetic Research and Health Services Research.

MEDICAL ADMINISTRATION AND MISCELLANEOUS OPERATING EXPENSES

The 1986 request for this program is $55.9 million and 753 FTEE. These amounts reflect the effects of the 5 percent government-wide pay reduction, the GS/GM 11-15 grade reduction excluding Title 38 employees, a 10 percent administrative reduction and the phasing out of the Health Professional Scholarship Program.

Construction

The 1986 request for the two construction appropriations totals $611.6 million. An additional $160 million, available from previous appropriations, will contribute toward a total program level of $771.6 million. Included is $712.9 million for medical facility projects, $18.9 million for the National Cemetery program, $2.0 million for the Department of Veterans Benefits Regional Office program, $2.0 million for the Office of Data Management and Telecommunications, $500,000 for the year old Emergency Fund, and $35.3 million for General Administration.

There are 33 projects in the major projects construction request. Initial construction funding is requested for Philadelphia, Pennsylvannia; funding for the main hospital building for Houston, Texas, and renovations and replacement of buildings in Mountain Home, Tennessee also is requested. The major construction request for the National Cemetery Program is $12.5 million; $6.5 million is requested to provide for construction in Florida and $6 million is requested for a land acquisition in Northern California for a National Cemetery. The construction program also continues to emphasize the correction of life safety and other code deficiencies. Two new nursing homes are scheduled for construction in Amarillo, Texas and Tucson, Arizona.

This concludes my prepared statement, Mr. Chairman. My staff and I will be pleased to answer your questions regarding the 1986 budget estimates of the Veterans Administration.

Chairman MURKOWSKI. I would like to ask Senator Matsunaga, who has just joined us, and who is one of the senior members on the committee for an opening statement.

I see that you look quite relaxed and refreshed, you must have just returned from your very warm State.

I left my State at 5:30 a.m. and it was 38 below and it was a vigorous departure and 9½ hours later, I assume that we both got here.

Welcome to the committee, Senator Mutsunaga.

Senator MATSUNAGA. Well thank you, very much, Mr. Chairman. First of all, I wish to congratulate you upon your elevation to chairmanship of this great committee and second, I thank you for reminding me that places like your State make Hawaii seem even more like heaven.

I apologize for my tardiness. But I would suggest that maybe we should start not at 1 p.m. because that interferes with my lunch, with my constituents, but I have no opening statement.

Chairman MURKOWSKI. Thank you, very much, Senator Matsunaga. You were given an opportunity and you handled it ideally.

There are only three of us here, so I assume, Harry, we can get through your presentation rather quickly.

The question on the Loan Guarantee Program is one that you and I have had some discussions on. The proposal is to raise the origination fee from 1 to 5 percent. I wonder if you could enlighten me as to whether or not those points would be up front, in the sense of an increase in a downpayment form, or would the increase from 1 to 5 points be added onto the principal amount, so all that would really be done would be to increase the monthly payment.

Could you also indicate what it might be on an average veteran's mortgage? How much more would it cost the veteran if they threw 5 points onto the average veteran's loan?

Mr. WALTERS. Senator, I think the veteran has the option of paying that up front cost in cash, which is unlikely since most of the users of this program are not financially able, or they can finance it over the period of the loan. That would raise the average payment by less than $50 a month.

Is Bob O'Toole here?

Mr. O'TOOLE. The payment on the average loan of $68,000 would increase by about $29 a month.

Chairman MURKOWSKI. So the average veteran's loan amount is $68,000 then, and that's amortized over what time period?

Mr. O'TOOLE. 30 years.

Chairman MURKOWSKI. So 5 points from 1 point is a 4-point difference, and you're saying that would increase the veteran's monthly payment $29 a month?

Mr. O'TOOLE. Something near $29 to $30 a month.

Chairman MURKOWSKI. I would like to have that for the record of this hearing, specifically on the cost for an average mortgage. It is my understanding that that amount would not be a downpayment. The veteran would have the option, as Harry Walters stated, to pay it up front, but more likely the veteran would finance it. So that's what it would mean?

Mr. O'TOOLE. Right.

[Subsequently, the Veterans' Administration submitted the following information:]

The estimated average guaranteed loan amount for fiscal year 1986 is approximately $67,900. Based on this loan amount, at an interest rate of 12.5 percent, the monthly payment would increase by $29 a month if the 5-percent funding fee were financed over the life of the loan.

Chairman MURKOWSKI. Mr. Walters, can you enlighten us a little bit on why OMB felt that it was necessary to try to initiate a fee structure that would offset some of the foreclosure costs and the inability of the reserve accounts to fund the problems associated with veterans' foreclosures?

Mr. WALTERS. It's a very simple answer. It's $400 million which would no longer be required out of appropriated funds in order to bring the account into balance.

Chairman MURKOWSKI. Wasn't the account out of balance about $600 million?

Mr. WALTERS. It was out of balance last year. We asked for $306.6 million last year in the supplemental and we were provided with that.

So the account is not in order, and it's understandable why OMB would have concern about it. I have concern about it myself.

Chairman MURKOWSKI. Well, I do, too, so there's three of us at least that have concern about it. I am told that there are 20-some-odd thousand foreclosures. Then I was told there were 11,000 more, which makes some 30,000 to 33,000. They may be in a different status of foreclosure, but it would seem to me that this proposal is a stopgap. I am not suggesting that it is not enough. I'm just wondering if this is the appropriate way to carry reserves which obviously, on an actuarial basis, are going to be called on, because foreclosures will exist. One minute to come in for a supplemental and the next minute to come in with five points seems to be a lack of relating to what the real problem might be.

I wonder if the VA has a better proposal for what the ills of this program really are.

Mr. **Walters**. I'm not so sure we have a proposal that will cure all the ills. But I have ordered an IG investigation into the initial home appraisals that we use in making a loan so that we can find out whether we're appraising those homes appropriately. The homes may be overvalued and on foreclosure we're taking a bigger loss than we thought. We're taking a look at that area.

We're taking a look at streamlining the time when a veteran's home is in jeopardy to the time when we finally foreclose. That time is expensive.

The fact is that foreclosures are there. We previously looked at the problem in terms of letting the bank have the property. Last year we determined that in many cases the cost of doing that was in fact more than the current policy of property acquisition. So that doesn't seem to be a reasonable avenue.

Other than that, we do not have any particular ongoing course of action which would make the loan guaranty program more efficient.

The 5-percent user fee, by the way, is a Federal-wide policy. It goes across FMHA, FHA, and the VA.

Chairman **Murkowski**. So you're saying these are uniform within FHA and other programs that the Government provides. So they would equate then to the standard fee structure. The only difference for veterans is that they would receive a lower rate of interest. I do not believe there's any downpayment requirement on the veterans' mortgages, is that correct?

Mr. **Walters**. That's correct.

Chairman **Murkowski**. Well, the committee would appreciate your recommendations reflecting on some of the cures associated with these ills, because I certainly don't have any confidence that the request of OMB is the answer to the problems associated with the adequacy of the reserve account, but perhaps something else would be. We've already heard from some of our members with regard to their attitude towards a five-point fee structure as basically killing the veterans' mortgage program. But indeed, if the cost is whatever it was, $29 a month or thereabouts, that doesn't necessarily kill the program, but the question I think we have to responsibly ask ourselves is, is that adequate to cure it? I'm not convinced of that.

Can you tell us in what specific ways the DVB consolidation plan will effectively utilize the "target system," with or without enhancements? Is funding going to be required to design new automation, or do you have that capability already?

Mr. **Walters**. Well, we do not have the specific answers to any of those questions. The agency has not had time to digest consolidation in terms of planning or implementation since we just learned of it in late December.

But we are looking at automation, trying to ascertain where efficiencies can be obtained by utilizing modern technology. And whether consolidation happens or not is dependent upon whether or not it can be accomplished as a part of new directives on automation.

The VA is somewhere near where Sears and Roebuck was 20 years ago in dissemination of information. It's hard to get information from San Francisco to Miami, sometimes impossible unless you use air express. So we have an information distribution problem, and we need to face up to it, take a good look at it, not only now, but for the long haul.

For the long haul for sure, we are very antiquated and we need to get on with the use of modern technology.

Chairman MURKOWSKI. In view of the fact that the Department of Veterans Benefits is projected to reduce its FTEE level by 600 to 700 during 1986 in connection with the planned consolidation, can you explain if the 5-percent pay reduction proposal would reduce FTEE levels beyond those reductions I just mentioned?

Mr. WALTERS. I'm not so sure I understand that question, Mr. Chairman.

Chairman MURKOWSKI. Well, it's my understanding that the Department of Veterans Benefits is already planning to reduce its current FTEE level by 624 during fiscal year 1986. Will the 5-percent pay reduction proposal be implemented by reducing FTEE, or their pay levels, and will it result in a reduction beyond the 624 planned cutback in FTEE within the Department of Veterans Benefits?

This evidently is an important question, because the staff has it right up here in order of preference. If you do not understand it, I guess I do not, either. Maybe we ought to ask the staff.

Is this an important question?

Mr. WALTERS. Could I take the opportunity to make a comment in reference to that?

Chairman MURKOWSKI. Sure, go ahead.

Mr. WALTERS. We have commissioned a study by Arthur Young & Co. to look at the work measurement system in the Department of Veterans Benefits. This is my third budget in the VA, and every year we wonder whether we have the right amount of employment in the Department of Veterans Benefits.

Unfortunately, that study just wasn't completed in time for my third budget. We're about 2 weeks behind. By the first of the month, or shortly thereafter, we should have that study in hand. The study will provide recommendations to improve the work measurement system. This revised system will give us a better handle on the staffing requirements for DVB to get the job done efficiently.

Chairman MURKOWSKI. I understand you're contemplating expanding the number of regional offices located on medical center sites. Are there any sites now being considered for inclusion in the VA's major construction program for 1986 through 1990?

Mr. WALTERS. We'd be pleased to supply that for the record. Mr. Hagan may have to do it for the record.

[Subsequently, the Veterans' Administration submitted the following information:]

The 1986-90 VA plan to colocate regional offices to hospital grounds includes the following DVB regional office locations:

Regional Office	Medical Center
Fargo	Fargo.
Wichita	Wichita.
New York	St. Albans, Brooklyn, or Northport.
Newark	East Orange.
Reno	Reno.
San Francisco	Palo Alto or Livermore.
St. Paul	Minneapolis.
Chicago	Hines.
Des Moines	Des Moines or Knoxville.
Los Angeles	Los Angeles.
Winston-Salem	Salisbury.
St. Petersburg	Bay Pines.
Houston	Houston.
Montgomery	Montgomery.
Boston	Boston or Brockton.
Detroit	Detroit or Allen Park.
Hartford	Newington.
Cleveland	Brecksville.
Boise	Boise.
Columbia	Columbia.
Indianapolis	Indianapolis.
Lincoln	Lincoln.
Manchester	Manchester.
Roanoke	Salem.
St. Louis	St. Louis.
Milwaukee	Wood (colocation completed 1983).

However, on February 11, 1985, the VA Administrator met with the Deputy OMB Director. At that time, it was agreed that VA would develop a plan for modernizing its entire operations and would consider various efficiency alternatives; i.e., DVB consolidation and/or colocations.

Chairman MURKOWSKI. When will you get the results of the Arthur Young study?

Mr. WALTERS. We hope to have that in a couple of weeks. I understand that the Acting Chief Benefits Director is to be briefed next week.

Chairman MURKOWSKI. Senator Denton has joined us.

Senator Denton, I indicated to our witnesses and distinguished guests that you were chairing the Senate at 1 o'clock and that's why you were not with us. Do you have an opening statement or any comments?

Senator DENTON. I do, Mr. Chairman, and thank you for making that announcement. That's the only thing that would have deterred me from being here on time.

I'm glad to join you, Mr. Chairman, here for the opening of the Senate Veterans' Affairs Committee hearings on the Veterans' Administration budget request for fiscal 1986, and I'm pleased also to join Harry Walters and Ev Alvarez, with whom I've had many dealings and a very long association.

I know that you, Mr. Chairman, will continue the fine tradition established by Senator Simpson, and I look forward to working with you.

I'm glad to be here with the new Chief Medical Director, John Ditzler, and I'm glad to see Don Shasteen and his colleagues from the Department of Labor.

But most important, I'm grateful to see the distinguished leaders of our national veterans organizations.

I have not heard the other opening statements, so I don't know where mine's going to fall on the spectrum, but we can start out with an obvious statement, that we've got to find effective ways of meeting the needs of our Nation's 28 million veterans. That number is growing. The families and survivors being included, we have a total of 81.5 million people, or 34.5 percent of our population, eligible to receive VA benefits. And that's a tremendous responsibility which the committee and the Veterans' Administration has to handle in a fair and equitable manner.

The President has requested $27.1 billion to fund VA benefits, medical, and construction programs for 1986, and that is only $123 million less than for fiscal 1985. We might say that, compared to the budget reductions proposed for other agencies, the VA has come out pretty well, but I don't like to have it talked about that way. We must be sure that we do not view veterans benefits as if they were some welfare or discretionary program.

They're not. And I'm seeing it talked about that way. Likewise the military budget, armed services matters, are being talked about in terms of so many billions of dollars being this much savings and so on, in the same way they're talking about cleaning up the abuse in some welfare program. Well, I don't dig that at all, and I intend to fight that kind of approach to the protection of the security of the United States.

The principal reason for being of any government, including this one, is to provide for the common defense, and in that regard we have veterans, men and women, who have served to do that. And I don't see talking about them in terms of savings, or in terms of how we're going to cut their programs similar to the way we would cut a welfare program or some discretionary program.

We have an obligation to those men and women, and particularly to those who have served in combat. Those who were disabled as a result of their combat service must have our first priority. I suggested that to Senator Simpson when he took this chairmanship over several years ago, and he has undertaken to work in that direction.

We must ensure that we do nothing to impair the benefits to them, that is, those who were disabled, and to the other veterans to whom we've made a national commitment rooted in legislation that has been in effect for many years. It may be that we're providing some benefits for which there is no such commitment. One may have sneaked in somewhere that maybe we shouldn't have, or that we provide some veterans with benefits to which they are not truly entitled. I think by their own judgment this can be worked out.

We must, however, deal with these problems on the basis of careful examination and consideration. I'm sure, Mr. Chairman, you agree that we must understand the difference between the things that we are as a nation obligated to do and those things that we do because of any of several other reasons. We must ensure that we do not penalize our veterans in the course of a well-meaning but misguided effort to cut expenditures "across the board" without regard to the need or obligation of the particular program being cut.

The benefits program, comprising 59.3 percent of the total VA budget, is $306.3 million higher than the level for the current year. The requested compensation in pension cost-of-living increases will help provide a suitable minimum income for the men and women who have served our country so well, and I'm pleased to see that kind of consideration this year financially.

I'm glad to see also that the amount for medical programs, which is 35.5 percent of the budget, has increased by $236 million. The VA clearly is committed to providing quality health care to our veterans. People keep talking about how the cost is going up, and it has no relation to the veterans. It has to do with medical cost, and it also has to do with the simple fact that more and more veterans are coming into the age group in which they are qualified to receive the medical benefits that this country justifiably is committed to.

The construction program's request this year has been decreased by $151 million, and the VA asserts that it's carefully assigning priorities to the facilities that need immediate attention. I trust that the Administrator will do that, as he has done so many other things well.

But I must say something that is not entirely aimed at a particular parochial interest of mine, and I want to emphasize it. It is that our budget deficit today and the prospects for the future suggest that we must find less expensive but more effective ways of providing facilities. We can't just keep going the way we have been going.

I suggest that the committee consider and then suggest that the VA seriously and actively investigate the conversion of existing facilities for medical and nursing care rather than continuing to pay for the construction of new ones. That's very high cost. You encounter the high interest rates of today when you do that. And you encounter the higher costs of construction and materials.

Now, we are still going that way too much. We're continuing to build them, and there are some darn good medical facilities around that exist which can be bargains. That means that, if we take advantage of those bargains, we can save money and treat more people more effectively. It doesn't necessarily equate that if you save money, you necessarily lose the ability to provide care.

Now, that course of buying existing medical and nursing care facilities has been suggested in a number of high level studies, and one is from the VA itself. There are several from OMB. The VA's study, "Caring for the Older Veteran," recognized that a gap between health-care beds needed and available might have to be filled by "leasing or purchasing facilities operated by the VA."

In other words, not just building a new one, but leasing or purchasing facilities that already exist. I would like to emphasize that point. I will be asking you later, Mr. Administrator, about a particular case in point which you wrote me about; I just received the letter today. It's not entirely clear to me what you mean by that letter. I understood that particular matter was going to be handled at the local level, that you preferred not to handle it at the top. Now it seems that you may have been reversing that position. That's sort of like code words, but you understand what I mean, so I'd appreciate an answer today before I leave.

I'm pleased that the general operating expenses, 2.9 percent of the VA budget, have decreased $4 million from fiscal 1985, and I know that Harry and Ev are responsible for controlling those costs. I'm confident they will apply the same kind of creative cost reductions to other parts of the budget. We all should pat them on the back for the visible evidence that the VA is limiting its own operating expenses and spending money where it's truly needed, on the veterans.

Now, I want to be careful that you don't create a comparison between a veterans program and a welfare program. I'm saying that we must be very careful not to. But in order to point out the efficacy of what Harry and Ev are doing here, we can look at something that Dr. Thomas Sowell, a Ph.D. who happens to be black, out at Stanford University, keeps saying about our welfare programs. He says if one-third of the money appropriated to help the poor, if one-third of that money that's appropriated by Congress in the name of helping the poor were to reach the poor, we would have no one in the United States left in poverty. And that's a fact.

There are many other economists and government analysts who are saying that. That's what's wrong with our welfare system. In other words, the bureaucracy sops it up. OK, in the case of the veterans, there has been some bureaucracy sopping it up, but these two gentlemen are eliminating that by leaps and bounds. I congratulate them for that.

The problem will become more serious in years ahead. The pressures on the Federal budget will continue to be severe. It will take creative thinking, effective cost control, and continued good management so we will be able to take care of a larger number of older veterans. It's a problem in my State as well as in the States of all of the colleagues here at the table and all on the floor of the Senate. I expect that the leaders of the VA will work with us to find ways to address it effectively, in a manner that responds to the needs and concerns of the veterans themselves and to the needs of this country.

Under your leadership, Mr. Administrator, the VA has continued its proud tradition of treating America's veterans and their families with the care and dignity that they genuinely deserve. I and my colleagues on the committee greatly appreciate your devotion to the welfare of our veterans, of whom you and Mr. Alvarez are such shining examples.

Thank you, Mr. Chairman.

Chairman MURKOWSKI. Thank you very much, Senator Denton. Senator DeConcini.

Senator DECONCINI. Mr. Chairman, I, like others, have to be someplace else but I have a few questions and would like to also have the record open long enough to submit some written questions.

Chairman MURKOWSKI. The record will be open for 10 days.

Senator DECONCINI. Thank you.

Chairman MURKOWSKI. Is 10 days sufficient for staff?

Senator DECONCINI. That will be quite sufficient. And I thank the chairman.

Mr. Walters, assuming that Congress does not pass your proposed legislation to make an across-the-board 5-percent cut in Federal employees' pay what is the administration's intention with respect to requesting supplemental appropriations for the resulting shortfall in fiscal year 1986 budget requests for employees' pay?

Mr. **Walters**. I do not know. I have not discussed that with anyone, Senator.

Senator **DeConcini**. I only suggest that maybe you start discussing it because I feel some mood here in the Senate that we are not going to do that, certainly not to veteran employees or other ones.

Can you describe the impact of OMB's directed reduction in the number of GS–11's to GS–15's positions in the DM&S? If you could focus on the general implications of this reduction on the agency's ability to recruit high care health-care personnel, especially those employed under title 5 and the impact on the reductions of the funding resources available in the DM&S?

Mr. **Walters**. Let me ask Dr. Ditzler to answer that question, Senator.

Senator **DeConcini**. That is fine. Thank you.

Dr. **Ditzler**. Senator, we have gotten relief on the GS–11 to GS–15 reduction for title 38 employees, which is the physician/nurse group. We have not gotten relief for the General Schedule civil service account. That impacts us primarily in the high technical skills in psychology, hospital administration, nuclear medicine technicians, and advanced radiology technicians.

We are currently reviewing the impact. But I believe it is safe to say that with the activation of new facilities in the next year or two, we may have great difficulty with the GS–11 to GS–15 restrictions.

Senator **DeConcini**. So I can gather that from your standpoint that it is going to be very difficult and that it will have a significant impact if it is implemented?

Dr. **Ditzler**. It will in time. Right now we are living with it and surviving, but I think in time it may have a serious impact.

Senator **DeConcini**. What period of time? Less than 1 year?

Dr. **Ditzler**. I would expect in about a year.

Senator **DeConcini**. Thank you.

Mr. Administrator, with regard to the 1-percent productivity increase which is discussed at page 5–34 of the VA budget document, can you explain how this level of productivity improvement was arrived at and how you intend to meet it and what occupations will be cut in order to make up the 1,916 FTEE reductions resulting from this action?

Mr. **Walters**. Senator, that particular policy is Federal-wide. A 2-percent efficiency reduction is being applied to many agencies. Recognizing, I suspect, the importance of medical care they passed back a 1-percent goal to the Veterans' Administration. We now have a 1-percent target to meet for management purposes and we are developing a plan to do that.

I will supply the plan for the record.

Senator **DeConcini**. When? When can we expect to have the plan? How do you intend to meet it?

Mr. **Walters**. I would suspect very quickly.

Dr. Ditzler, when?

Dr. **Ditzler**. We have an outline of how we would go about it but the final figure will not be available until we complete our target allowance process. Coupled with the plan will be the DRG approach to allocation and new methods and models for allocation of money to individual facilities. In essence, those who are least efficient will be hurt the most.

Senator **DeConcini**. Doctor, if you could answer me, when did you say you might have that information?

Dr. **Ditzler**. Budget targets will go out in April. So it will be sometime late May before our target budget will be developed.

Senator **DeConcini**. So we might have that sometime in the first part of April to review?

Dr. **Ditzler**. I would anticipate that, yes.

Senator **DeConcini**. I would appreciate it very much if you could make that available.

Chairman **Murkowski**. It will be if we would request, I assume.

Dr. **Ditzler**. Yes, we would make it available to you.

Senator **DeConcini**. Thank you, Mr. Chairman—it would be very helpful from the standpoint that the Appropriations Committee will be in the same process then, which I serve on, and I would have some interest in having that if possible before we take up that particular area.

[At the time of printing the above referenced material had not been supplied to the committee.]

Senator **DeConcini**. Can you tell me, Doctor, or perhaps Administrator Walters, what occupations will be cut to make up this or is this in the same process that will come forward when you have your target budget?

Dr. **Ditzler**. We would make no attempt to cut occupations. Rather, the accomplishment of reductions would be up to individual hospitals and it would be at their discretion.

Senator **DeConcini**. It would be at their discretion? So if you are going to knock off roughly 2,000 FTEE's after you get your target budget then you allocate it to the various institutions or hospitals and they have to come up with it themselves? Is that the procedure?

Dr. **Ditzler**. That is correct.

Senator **DeConcini**. Thank you.

Mr. Chairman, as I indicated, I have a number of other questions I will submit in writing. I thank Dr. Ditzler and Mr. Walters.

Chairman **Murkowski**. We look foward to receiving your questions, Senator DeConcini.

Senator Matsunaga?

Senator **Matsunaga**. Thank you. Thank you, Mr. Chairman.

How definite is your proposal to limit medical and hospital care for service-connected disabled veterans? Is that, is there——

Mr. **Walters**. We have no proposal to do that.

Senator **Matsunaga**. No proposal?

Mr. **Walters**. Service-connected veterans are exempt from all the proposals that have been discussed or have been projected in the budget.

Senator **Matsunaga**. What I meant to say is to limit to disabled—to service-connected disabilities. Do you propose to eliminate hospital medical care for disabilities non-service-connected?

Mr. **Walters**. No, we do not.

Senator **Matsunaga**. You do not?

Mr. **Walters**. We do not.

Senator **Matsunaga**. Well, I am glad to hear that. I thought you were proposing that.

Mr. **Walters**. No, sir. That is not, the case.

Senator **Matsunaga**. So the reports I got I must have been misinformed. So you——

Mr. **Walters**. It's quite a complicated eligibility criteria. I can understand why you could wrestle with it. We wrestle with it a lot. But serving the service-connected veteran is our primary goal. Then there are other categories of non-service-connected which we are mandated by law to care for, such as former POW's, agent orange related diseases, exposure to radiation, World War I veterans sometimes, and so on.

Those categories include non-service-connected veterans, but they are mandated. We also have a category of non-service-connected veterans under that who are entitled to VA care on the basis of need if they are under the age of 65. Over the age of 65 they are entitled to VA care, without having to show a need. That's the law as it stands, today.

We have asked that that law be reviewed and repealed so that it can be indiscriminately applied to all non-service-connected veterans who are otherwise eligible for care.

Senator **Matsunaga**. Without regard for age?

Mr. **Walters**. Without regard for age. All the——

Senator **Matsunaga**. Would that be restricting eligibility or opening up eligibility?

Mr. **Walters**. Well, it is a combination of the two. If the aging veteran population grows, as we project it will, then veterans over the age of 65 who choose to use the hospital regardless of their ability to pay, that is, those who could afford to go elsewhere, would place the Veterans' Administration in the position of having to displace somebody under the age of 65 who does not have the ability to pay, because we only can offer service on a space available basis. I am not sure that space is going to be available for all.

So what I have asked is to make this policy nondiscriminatory. Most of the Vietnam veterans are under the age of 65 so the Vietnam veteran group is treated disproportionately by that law.

Senator **Matsunaga**. In your consolidation proposal do you have intentions of eliminating any offices in Hawaii or the West Coast?

Mr. **Walters**. None that I know of. We just haven't had time to examine the consolidation plan in depth to answer that kind of question. The automation process will dictate our future actions.

Senator **Matsunaga**. In the loan servicing fee on VA loans do you propose it to—do you propose to raise it from 1 to 5 percent?

Mr. **Walters**. Yes; this is the administration's proposal.

Senator **Matsunaga**. But how much——

Mr. **Walters**. We will raise it from 1 to 5 percent.

Senator **Matsunaga**. How much do you expect to save by that?

Mr. **Walters**. If there is no reduction in the amount of loans made, we would expect to collect some $600 million. We would expect to add to the fund $600 million which would cover our shortfall, so we would not have to ask for appropriated funds for the program.

If the loans are less than what we would expect then the money would be less as well.

Senator **Matsunaga**. What is the commercial rate at this time, do you know, on servicing loans?

Chairman **Murkowski**. About ten-and-a-quarter.

Senator **Matsunaga**. What?

Chairman **Murkowski**. Ten-and-a-quarter. Are we talking about prime?

Senator **Matsunaga**. No. Servicing fee.

Chairman **Murkowski**. Oh.

Mr. **Walters**. Servicing fee?

Senator **Matsunaga**. Yes.

Mr. **Walters**. One percent. Is that typical across the board for private lenders?

Senator **Matsunaga**. No. Servicing fee right now is 1 percent by VA?

Mr. **Walters**. Oh, yes. For the VA it is 1 percent.

Senator **Matsunaga**. What is it in commercial, in the commercial area?

Mr. **Walters**. There is no user fee in the private lending business. Is there?

Chairman **Murkowski**. I would suggest there is.

Mr. **Walters**. It wouldn't be known as a user's fee. It would have to be points up front.

[Subsequently, the Veterans' Administration submitted the following information:]

Conventional lenders require private mortgage insurance on low downpayment loans. For 5-percent downpayment loans [the smallest downpayment loan available in the private market], insurance premiums of 1-percent cash up front plus one-half percent per year are typically required.

Chairman **Murkowski**. No. Just points up front.

Mr. **Walters**. But——

Chairman **Murkowski**. It ranges from whatever the market dictates and the risk to the lender and so forth. Points over all.

Mr. **Walters**. The VA generally prohibits veterans from paying those points now. This user fee is above and beyond points.

Senator **Matsunaga**. I don't think it is beyond, well, even up to 5 percent. I think it is lower——

Chairman **Murkowski**. My understanding is that it is points. That it is 5 points and the market is 2, 3 points, depending on what kind of a mortgage lender you deal with.

Senator **Matsunaga**. What I was searching for is how you based your elevation from 1 percent to 5 percent if you don't know what it is in the commercial area, what standard did you apply to raise it from 1 percent to 5 percent?

Mr. **Walters**. I would suggest that the standard was sort of drawn out, out of the air in order to supply enough income, in order to supply enough income to make up for the deficit in the account.

Senator **Matsunaga**. Well, if you——

Mr. **Walters**. That is the way it was derived.

Senator **Matsunaga**. If you go beyond what is being charged in the commercial field then you would be punishing the veterans, would you not be? You would be penalizing?

Mr. **Walters**. Yes and no. I think there is reason for caution, though I would agree with you there. The increase might penalize the veteran.

We don't require a downpayment for the veterans' loans.

Senator Matsunaga. Well, may I suggest that you have your staff look into this matter of what it is as compared to the commercial area?

Mr. Walters. We have looked into it. We would be happy to supply that to you personally and for the record, Mr. Chairman.

Senator Matsunaga. Yes. Because 5 percent seems a little high to me.

Chairman Murkowski. Before you came in, Senator Matsunaga, we had some discussion about the 5 points and just what constitutes the rate structure within the conventional market. Obviously, raising it from 1 point to 5 points is significant and the rationale behind that, whether it would be sufficient to constitute reasonable reserves is something that the Veterans' Administration is going to provide for us.

In any event, the difference between the conventional market and the veterans' market is that there is no downpayment required in the veterans; and that is obviously an incentive for the program, as it should be. The interest rate structure is less than the private sector by 1 to 2 percent. We know that for a fact. There is usually mortgage insurance required in the private sector whereas there is not on the veteran's mortgage.

We will look forward to more information on that.

The question which I posed is since the VA has requested supplementals to cover losses associated with the 20,000 to 33,000 foreclosures, whatever they currently might be, the question of 5 points does not seem relevant to the problem. The problem is how do you handle and recover reasonable costs associated with foreclosure? All they have done here is throw 5 points at us and said this will help. On the other hand, the VA might still be in for supplementals.

So I think you are absolutely correct in saying we should have more information on the status of this.

Senator Matsunaga. Well, I am taking too much time here, Mr. Chairman, so I will submit whatever other questions I have in writing.

Chairman Murkowski. Thank you, Senator Matsunaga.

Senator Denton.

Senator Denton. If Congress doesn't pass the 5 percent pay reduction for Federal employees, how are you going to regard that $200 million portion in the VA budget which is responsive to a 5-percent pay reduction? Will you continue to look for ways to save $200 million or are you going to forget about it?

Mr. Walters. We have not really addressed that particular area.

Senator Denton. OK. That is all right.

You went into the way, if I understood you correctly, you said the service-connected guy, say Vietnam, did you imply that if someone is over 65 he could get preference to a service-connected disability, say, in the case of a Vietnam veteran? You did not say that?

Mr. Walters. I did not say that. When a non-service-connected veteran reaches the age of 65, he does not have to sign an oath that shows he cannot defray the costs of care. The law states today that a veteran under the age of 65 must sign such an oath.

Senator **Denton**. How would you like to see that law changed specifically?

Mr. **Walters**. I would like to repeal the over age 65 law and require that all veterans who are need connected show their need. The VA would still be treating service-connected veterans as their primary clientele. Other non-service-connected veterans who we are mandated by law to serve would be treated secondarily. And finally we would care for those veterans whose medical care needs are not associated with service or specifically mandated, on the basis of need, not age.

Senator **Denton**. OK. I mean, I would like to cooperate with you on that. Have you been having any trouble getting anybody to offer a change?

Mr. **Walters**. Well, I have not sensed that there is any great consensus developing one way or the other. I feel very strongly about it because from a fairness point of view the Administrator and every medical center director in the system is going to be required to make those judgments in the future. I think we are throwing out some false expectations to our older veterans who may think that they have access to the VA health-care system even though they can afford to go elsewhere.

If in fact that displacement happens, I think we have been unfair to those who do have a legitimate need for VA care because they can't get it anyplace else.

So, from a fairness point of view, I urge the Senate and I urge the House of Representatives to take a very good look at that law. Hopefully, you will subscribe to our views so we can administer the law in a fair and equitable manner.

Senator **Denton**. What about if the injury or illness is in the field of sort of catastrophic, and the individual can afford to go and get medical care elsewhere, but it is going to cost him or her her life savings and so on, put him into debt?

Mr. **Walters**. Under the test which we will present to the Congress, the Administrator will be able to waive the need to pay under such catastrophic illness environments.

Senator **Denton**. Congress and the administration really have not dealt with catastrophic illness in the general sense yet, and I hope we get about it somehow.

Is there a discrepancy in that the combat injured veteran is not given preference of the highest order? Is there any—What special provision is in effect for him? I must say that, in looking at some hospitals that I used to visit annually, I would see perhaps 40 patients in a given ward and they would not be getting the red carpet by any means. It was good. There was a lot of volunteer work going on there. It was probably acceptable. But I just feel that for someone who was injured in combat and seriously injured, there ought to be some precedence, some priority given to that guy, particularly if it is a sweeping injury like losing two or more limbs, I think that guy ought to get a more red carpet treatment than any other category.

Is there any provision or any slant like that in the way that the hospital treatment is set up?

Mr. **Walters**. There is not. There was a law or a regulation, I'm not sure which. Dorothy Starbuck, former Director of Veterans

Benefits, who was with us for 40 years and just retired, reminded me the other day that there was a law one time that limited peacetime-disabled veterans' compensation rates to 80 percent of the rates payable to wartime-disabled veterans. That was the law at one time.

Senator **Denton**. How many? How many, Harry? Noncombat, how many percent?

Mr. **Walters**. Eighty percent versus a hundred. That was a law or regulation at one time, but it was repealed. I don't know the origin of it. It was repealed because it was very difficult to administer, as Dorothy Starbuck tells me.

Senator **Denton**. Is there any way that you can think of, or do you think it is needed from what you have seen out there, that some kind of emphasis be given to the quality of care for a seriously injured combat—he got it in combat?

Mr. **Walters**. Well, I think we just administer the law as it is today, and that means that those who show that their illness or injury is a result of service to one's country, combat or not, are compensated accordingly. The debate on whether or not combat veterans should have primary use of the system has not been on the front burner, and certainly not on mine. I suspect we could run into many pitfalls and some minefields in that discussion.

Senator **Denton**. We sure do. Especially, you know, political. But in all fairness, if there is some lowest common denominator of quality of care and it is spread across guys who were out of the service for 40 years and then in an automobile accident—and this is what I saw—and they are in there with a guy who had his limbs blown off in Korea, Vietnam, World War II, getting exactly the same care, and it isn't all that red hot, I'm not sure that combat guy shouldn't get a better hack at it unless the others would be reduced to what wasn't acceptable.

Maybe I am not expressing myself well and maybe I have a flawed idea, but that is the way I tend to view it.

Mr. **Walters**. I think we have room for all service-connected veterans at the present time in our system. Service-connected veterans having primary eligibility already get full access to the VA health-care system. Many of the veterans who are in training accidents or airborne accidents, and who are quadraplegic or paraplegic have significant productivity reduction in their lives. Those service-connected veterans are cared for in the VA hospital care system and in our nursing home care system with great compassion and care, whether they were in combat or not.

We have that kind of capacity available to treat all of those veterans.

Senator **Denton**. So if a gentleman, say, 3 months in uniform in World War I, never got outside the country, 45 years later gets in an automobile accident, has the same kind of injury as a guy that, say, was messed up in Grenada, they are both going to get good treatment and, therefore, there is no need to discriminate between the two, is that what you are saying?

Mr. **Walters**. That is essentially correct.

Senator **Denton**. I have some other questions which I will submit in writing, Mr. Chairman. But I am glad you have clarified that for me, Harry.

I have got to go back over for the Meese hearings, too.

But I'd like to know, when will the veterans themselves start testifying?

Chairman **Murkowski**. In just a few minutes the various veterans' groups will testify before the committee, Senator Denton.

Senator **Denton**. Thank you, Mr. Chairman.

Chairman **Murkowski**. The record will be open for any questions that you may care to ask.

I have two more questions. The first is for Dr. John Ditzler. This involves the situation surrounding the proposed Houston veterans' hospital.

It is my understanding that only about 8 percent of the current inpatient population of the Houston VA Medical Center is service-connected. The question is the proposal to build a new facility of about 1,047 beds, and of course we have the concerns of construction needs in other parts of the country, when there is such a low occupancy of service-connected patient population. I would appreciate you enlightening us on why the Houston replacement hospital is the No. 1 priority for fiscal year 1986, yet it represents such a small number, 8.8 percent as compared to the national average which I understand is about 30 percent? Generally speaking, veterans' hospitals have ranged from 500 to 700 to 1,000 beds, so this is one of the biggest ones proposed.

Can you enlighten the committee a little bit on that case?

Dr. **Ditzler**. I am reliably informed, Senator, that it is 22-percent service connected. This was the average for 1984 for veterans with service-connected disabilities who are receiving care for service-connected and non-service-connected disabilities.

Chairman **Murkowski**. Are we into non-service-connected or service-connected illnesses?

Dr. **Ditzler**. We make no differentiation. These were service-connected veterans, and that is the only differentiation we made.

Chairman **Murkowski**. Then this figure could very well be right, because I gave you a figure of 8 percent of the inpatient population being service connected.

Dr. **Ditzler**. Well, our records show only whether they are service connected, not whether they are service connected because of combat or noncombat type of injury.

Chairman **Murkowski**. Well, go ahead and reflect in any event. This is one of the larger hospitals.

Dr. **Ditzler**. Yes, it is.

Chairman **Murkowski**. When we are talking about building hospitals a little smaller, 500 to 700 beds, we suddenly get one with 1,047 beds. You said that it is up to 22 percent for all, and I say that it is 8.8 percent for service connected, so let's assume that we are both right.

Why such a big hospital?

Dr. **Ditzler**. We have, in addition to service-connected obligations under current law an obligation to all other non-service-connected veterans as space and resources are available. In addition, we have the mandates to cover the ex-prisoner of war. We have a mandate to cover all those seeking care because of possible agent orange related illnesses, radiation-related illnesses, Vietnam readjustment VA pensioners, World War I, Spanish-American War and numerous others as directed by the Congress.

So that when you add all of that together, we are dealing not only with a definition of service connection that may differ, but we are also adding other mandated workload. Generally, in most hospitals, and I cannot be specific to Houston, but we will send you the data, this workload can approximate somewhere between 70 and 80 percent of the total workload of the hospital.

Another reason that I can give you for either Houston or any other sizable type hospital is that it is an affiliated system where we attempt to maintain the medical expertise to provide quality health care to those 8 percent, or 22 percent, or whichever the figure should be.

We attempt to have a critical milieu of services within a VA medical facility and that requires that we provide on a space available basis care for those other veterans.

Chairman **Murkowski**. Well, in my mind, it is not a question, Dr. Ditzler, of the Houston hospital. It is a question about a replacement hospital in Houston. There are other areas of the country that have a higher percentage of service-connected veterans, which my reference tells me is about 30 percent. That compares with 8.8 percent at Houston.

So if we are going to compare something realistically, we are going to have to compare Houston's current 22 with whatever the Nation's average is.

My question to you, and you can supply it for the record, is within your own analysis in the Veterans' Administration, can you justify Houston as No. 1, which would be one of the biggest, based on needs in other parts of the country which according to the information that I have, and I would be happy to go over this with you perhaps at an appropriate time, that there are indeed others that would appear to have a higher priority based on a high percentage of utilization, as well as utilization for service-connected disabilities?

Dr. **Ditzler**. I think that you will find that 120 of the beds are nursing beds, and are not active acute care beds.

Chairman **Murkowski**. Well, I think that we both know what we are really interested in, trying to make sure that the priorities go to areas where there is the most demand. Obviously, all I can do is refer to the information that I have. I would appreciate you providing for the record of this hearing, an analysis of the percentage of occupancy by both service connected and nonconnected in relationship to various responsibilities that the VA has to cover throughout the country.

Dr. **Ditzler**. I would say, Senator, in general throughout the country, approximately 70 to 80 percent of the occupancy of all of our hospitals is due to care mandated in one way or the other by the Congress.

Chairman **Murkowski**. I am sure that is correct, Doctor. I do not dispute that at all. I am asking for something else, however.

Mr. **Walters**. We will supply that for the record, Mr. Chairman.

Chairman **Murkowski**. Thank you.

[Subsequently, the Veterans' Administration submitted the following information:]

The planning conducted by the Department of Medicine and Surgery must address the health-care needs of all eligible veterans. Section 5010 of title 38 requires that "the Administrator shall staff and maintain, in such a manner as to ensure the immediate acceptance and timely and complete care of patients, sufficient beds and other treatment capabilities to accommodate, and provide such care to eligible veterans applying for admission and found to be in need of hospital care or medical services."

The ratio of service-connected to non-service-connected discharges at Houston during fiscal year 1984 was 22.1 percent. The national rate for the same period was 29.8 percent. The 35-percent rate reported at the hearing was the percent of outpatient workload that is service-connected. The 1984 Patient Treatment Files are still under revision, so the actual service-connected discharge rates for Houston and the nation as a whole may be somewhat different.

Chairman. MURKOWSKI. The last question involves medical care. I would like your analysis on the acceptability of State nursing homes as a cost effective way to provide long-term care to the veterans.

In light of the budgetary constraints, and the increasing demand for long-term care, if this is in reality a good program, why have you come in for a decrease in the request for grants of construction of State homes?

Dr. DITZLER. We do believe that it is a cost effective program. This year we will be spending more than we spent last year. In the past, we have asked for greater new authority than currently shows in the budget.

Chairman MURKOWSKI. It says in my book that you came in for a $12.5 million decrease. I guess the question is, is that true? If it is true and your statement implies that it is a good program, why have you asked for less money? I commend you, but I am just curious.

Mr. WALTERS. Mr. Chairman, there is a law which requires that only one-third of those moneys can be spent in any one given region or State. We have asked for relief from that, because there are some States that really want to go forward in the nursing home care projects.

Some of these funds cannot be spent even though they are in the budget and appropriated for. I am making that as an overall statement, because I do not know for sure that we are indeed not spending everything that we get. But in fact, that is a blockade.

Chairman MURKOWSKI. Please provide that for the record, Dr. Ditzler, and let us know why you have got such a good program yet you are asking for less money. There must be a secret around here that might spread.

[Subsequently, the Veterans' Administration submitted the following information:]

The 1986 request for Grants for State Home Construction is $22 million which is $12.5 million lower than the 1985 request and appropriation. However, as described below, this is not considered to be an increase over the 1985 base level. Prior to 1985, no more than $18 million was ever appropriated in any given year. However, the VA requested $22 million for this program. OMB, recognizing the backlog in applications and the cost effectiveness of the program, increased the VA request from $22 to $34.5 million, an increase of $12.5 million. The 1986 request of $22 million recognizes the need to expand the funding base of $18 million which was the case prior to 1985 to a new base of $22 million.

Chairman. MURKOWSKI. That concludes my questions for the panel. I am sorry that I did not have an opportunity or take the opportunity to introduce the panel previously, but I am sure that they are all known. Of course, I want to thank you, Harry Walters, for your presentation and your responses to the questions. And also Mr. Alvarez, Dr. Ditzler, Mr. Hagan, and Mr. Bannai.

I think that we all agree, and I am speaking more or less for the members here, that we have an obligation. As chairman of the committee, I certainly accept the responsibility associated with the obligation to meet the requirements and the needs of the veterans as proscribed by Congress.

I certainly look forward to working with you, Mr. Walters. I continually heard your input. All of us who have had experience in organizations recognize that there is a trend, or tendency, within any organization to resist a certain amount of change and internal improvements.

I think that you would agree collectively, gentlemen, that there are ways that new ideas should permeate the system and be adopted and be instituted. I assure you that that is my pledge to you to work with you as we jointly assume the obligation with the tools that we have.

I thank you very much, and wish you well.

Mr. **Walters**. Thank you, Mr. Chairman.

Chairman **Murkowski**. It has been requested, Mr. Walters, if you can arrange with the gas station that in order to accommodate Senator Cranston, you might remain around until 3:15. I do not know whether the gas stations close at 3:16 or not.

Mr. **Walters**. Only at 6.

Chairman **Murkowski**. Thank you, gentlemen. We will call our next panel.

Donald Shasteen, Deputy Assistant Secretary for Veterans' Employment and Training, will be accompanied by Jeff Crandall, Executive Assistant; Joe Juarez, Director of the Veterans' Employment and Training Programs; and George Gonzalez, Director, Office of Veterans' Reemployment Rights, Department of Labor, Washington, DC.

In order to accommodate the next panel, who has waited so patiently for the first panel to conclude, as a consequence of the intense interest and questions, I do want to welcome you and ask that you proceed.

I believe, Mr. Shasteen, you will lead off.

We have a few questions for your panel, as well.

I welcome you to the committee and look forward to the role of the Department of Labor in addressing the needs and interests of veterans.

TESTIMONY OF DONALD E. SHASTEEN, DEPUTY ASSISTANT SECRETARY FOR VETERANS' EMPLOYMENT AND TRAINING, DEPARTMENT OF LABOR

Mr. **Shasteen**. Yes, sir. Thank you very much, Mr. Chairman.

I'll make it as brief as possible so that you can get to the veterans' organizations. I know they're all waiting to testify, also.

Chairman **Murkowski**. Thank you.

Mr. **Shasteen**. I want to, first, congratulate you and express to you the pleasure that we will have—that we look forward to—

working with you as the chairman of the committee, as we did with Chairman Simpson in the past.

I also want to commend you for the commitment that we felt was reflected at your first meeting as chairman in suggesting the proposal that you did. And we look forward to answering questions that you might have of us with regard to the proposal for those one-stop service centers for Vietnam veterans, as the questioning gets under way.

We appreciate this opportunity to appear before this committee to discuss the Department of Labor's fiscal year 1986 budget for veterans' employment and training programs.

There are four major areas that I would like to summarize: Funding for Federal administration of our programs; second, the Disabled Veterans' Outreach Program, called the DVOP Program; third, the Local Veterans Employment Representative Program known as the LVER Program; and finally, funding for veterans' programs under the Job Training Partnership Act, known as JTPA.

I'm pleased to report, Mr. Chairman, that our Federal staffing level for fiscal year 1986 is authorized at 282 positions, the same level as for fiscal year 1985. That includes, in the field staff, 40 positions for the Veterans' Reemployment Rights Program and 204 positions for the Veterans' Employment and Training Service.

And then, in the national office, 38 staff members.

The total funding level for staffing and operations is a decrease of $312,000 from the fiscal year 1985 level.

As you are aware, our Disabled Veterans' Outreach Program and our Local Veterans Employment Representative staff not only provide priority employment and training services to veterans through the national network of Job Service offices; but the LVER's also see that the Job Service, through all of its employees at local levels, give priority service to veterans, as required by title 38 of the United States Code.

Staffing levels for the Disabled Veterans' Outreach Program are determined by legislative formula and for the LVER Program by regulatory formula.

For fiscal year 1986, the DVOP staff level is 1,932 positions, compared to 2,035 positions for the current fiscal year, fiscal 1985.

Now, the funding level for 1986 is $60.9 million, compared to $59.2 million for fiscal year 1985.

So, while we have a drop of 103 positions, we have a slight increase, an increase of $1.7 million in funding for the DVOP Program.

The LVER staffing level for fiscal year 1986 is 1,489, compared to 1,598 for fiscal year 1985.

The funding level for 1986 is $50.6 million, compared to $50.1 million for fiscal year 1985.

So, there we have a decrease of 109 positions, and we have an increase of approximately half a million dollars.

The fourth major area affecting Veterans' Employment Programs is the Job Training Partnership Act. Title IV, part C, Veterans' Employment and Training Programs, provides that the Secretary of Labor, through this office, shall administer special programs for disabled, Vietnam-era, and recently separated veterans, those three categories.

Funding for this program is determined by formula contained in the Act. The funding level for fiscal year 1986 is $7.7 million, compared to $9.7 million for fiscal year 1985, a reduction of approximately $2 million in title IV, part C funding for employment and training programs for veterans under the Job Training and Partnership Act.

Now, that concludes my summary, Mr. Chairman.

I'd be pleased to answer any questions that you or the members of the committee may have.

Chairman MURKOWSKI. Thank you very much, Mr. Shasteen.

[The prepared statement of Donald E. Shasteen, Deputy Assistant Secretary for Veterans' Employment and Training, Department of Labor, follows:]

PREPARED STATEMENT OF DONALD E. SHASTEEN, DEPUTY ASSISTANT SECRETARY OF LABOR FOR VETERANS' EMPLOYMENT AND TRAINING, DEPARTMENT OF LABOR

Mr. Chairman and Members of the Committee:

Thank you for this opportunity to discuss with you the Fiscal Year 1986 Department of Labor Budget proposal as it pertains to veterans' employment and training programs.

Before I provide details about budget matters, I would like to mention a few items about which we are especially pleased and enthusiastic. Making the Office of the Assistant Secretary for Veterans' Employment and Training the principal focus for administering veterans' programs within the Department has proven beneficial. For example, having responsibility for the Veterans' Reemployment Rights program has improved our ability to respond in a more timely fashion to resolve veterans' employment problems; reemployment cases are generally resolved sooner, and those without merit are promptly provided assistance in finding other employment.

We have implemented our grants program under the Job Training Partnership Act (Title IV C), directed to meeting the needs of Vietnam-era, recently separated, and service-connected disabled veterans. We anticipate that we will be successful in meeting those needs and getting maximum results from the dollars available for two major reasons: the programs are planned at the State and local level and the grant process encourages the use of local matching funds. These factors will contribute to getting the most out of the dollars available. We have awarded about 65 grants thus far and almost doubled the amount available for special veterans' programs through the emphasis on matching funds as a criterion for selection of grantees.

We have also had the opportunity to develop and implement the Emergency Veterans' Job Training Program in cooperation with the Veterans Administration. We are confident that this major effort by two Federal agencies has proved to be very effective in helping veterans. To date approximately 28,000 long-term unemployed veterans have been placed. We have made the success of this program a high priority and we anticipate exceeding the program goal of 30,000 veterans placed in the near future.

We have also seen improvement in the productivity of the State Job Service agencies for veterans, as measured by the degree of priority delivered to veterans. The most recent national data available showed that veterans comprised 14% of all Job Service applicants, and 16% of all individuals placed by the State agencies. In prior years, veterans comprised the same percentage or less of the total placed as they did of the total registered.

Overall, it is accurate to say that the Department is providing better services to veterans now than in the past, and that veterans' unemployment is declining significantly.

Our budget request for Fiscal Year 1986 is $124.1 million. Included in this amount is $111.5 million for grants-to-States; $60.9 million for DVOPs and $50.6 million for LVERs. The funding is for 282 Federal positions, and 3,421 State agency positions allocated through grants-to-States. This Fiscal Year 1986 request represents a net increase of $1.9 million, and net decrease of 212 State agency positions compared to the Fiscal Year 1985 levels. Included in the Federal positions are the staff of the Office of the ASVET, the Veterans' Employment and Training Service (VETS), and the Veterans' Reemployment Rights program staff. Included in the State agency positions are the Disabled Veterans' Outreach Program (DVOP) staff and Local Veterans' Employment Representative (LVER) program staff.

Built-in increases of $4.6 million for the grants-to-States program resulted from anticipated mandatory State legislated salary and fringe benefit increases. Other major built-in increases of $1 million include: 1) an increase in non-personal services and postage costs, 2) increased general merit pay cost, 3) increased cost of administrative support services, and other items as explained in the summary of changes.

A total decrease of $3.8 million and 212 positions is proposed. This is composed of a built-in decrease of $1.2 million which is attributable to a decrease in disabled and Vietnam-era veterans population, and consequently a decrease in mandated positions in the Disabled Veterans' Outreash Program (DVOP), according to the legislatively prescribed formula. Program decreases totaling to $712 thousand represent saving achieved through the 5% Federal pay cut, a program freeze and savings in administrative services and overhead costs. Additional program decreases of $1.9 million were taken by the Local Veterans Employment Representative (LVER) program. This decrease resulted from a decline in the number of veterans registering at local States employment security offices.

As you probably know, FY 1984 was the first year in which the DVOP and the LVER programs were administered under discrete grant agreements. The agency now has two years' experience in negotiating grants to the States for these special programs. For FY 1986 the funds requested for each program represent the total costs of providing the number of DVOP specialists required by the legislative formula and the number of full-time equivalent LVER positions, administrative staff and non-personal services funding.

Emphasis will continue in early FY 1986 on DVOP and LVER involvement in intensive job development and placement activity. In addition, these specialists will continue their efforts in coordination with service providers under the Job Training Partnership Act, community-based service organizations, and other supportive service agencies to ensure the provision of comprehensive services to veterans.

As previously mentioned, we have implemented a competitive grant application system for distribution of funds to the States and/or Service Delivery Areas under the Job Training Partnership Act. The budget amount for Veterans' Employment Programs under JTPA, Title IV, Part C, is $7.7 million for FY 1986. As you are aware, Mr. Chairman, this funding level is determined by a formula contained in the Job Training Partnership Act. As I stated earlier, we expect that we will continue to have an effective progam due to the competitive structure and the preference given to those applicants that match or exceed the grant amount with local funds.

In closing, I would like to thank you for this opportunity to discuss the FY 1986 budget and how it affects veterans' programs. I will be pleased to answer any questions you may have.

Chairman MURKOWSKI. My line of questioning is going to revolve a little bit around the Emergency Veterans' Job Training Act, which has been, I think, a very worthwhile program. I participated in it when I was in the private sector, and it sets up a reimbursement of half the starting wage for qualified veteran trainees.

It's my understanding that $150 million were appropriated in 1984, of which $90 million has been obligated to date.

My question, specifically is: Under the program, for a certificiate of eligibility, it must be obtained by February 28 of this year. However, the training need not begin until September.

A gap between February and September could result in a veteran finding an opportunity, but because he or she has not applied by the February deadline, they'd be out of luck.

Can you address the realities of that, or is there a reason for that?

Or is there a reason why we can't accommodate them during that time?

Mr. SHASTEEN. Well, in the first place, that is correct. A veteran who does not sign up by February 28 would be out of luck if he is a Korean or Vietnam-era veteran eligible for the program.

By the same token, we have about 280,000 veterans who have been certified; reducing that by the renewals, that means about 220,000 veterans certified—individual veterans certified for this program. We don't have that many jobs certified. We have approximately, as we can best estimate now, some 30,000 to 35,000 jobs available under the program. We've set a target of 30,000 placements by March 1.

We have, as of last Friday, through the reports that we receive on a weekly basis from the local Job Service offices throughout the United States, placed 28,476 veterans in this program in just——

Chairman MURKOWSKI. Well, that was my next question.

Now, let's keep it simple. Since you can't—you don't have a number of jobs——

Mr. SHASTEEN. That's right.

Chairman MURKOWSKI. [continuing]. Available anyway, why not give those people an extension, at least, so that it coincides with the termination of the program. It doesn't make any difference apparently.

Mr. SHASTEEN. We certainly would have no objection to that. We have over 93,000 job slots available now.

Chairman MURKOWSKI. You would, then, consider extending the deadline for the veterans' application, so that these people theoretically wouldn't have to wait?

Mr. SHASTEEN. That's right.

Chairman MURKOWSKI. Even though you can't guarantee them a job?

Mr. SHASTEEN. That's right. It is a legislative matter—it would require——

Chairman MURKOWSKI. Well, then, you can do that administratively?

Mr. SHASTEEN. No. It would require legislation.

The February 28 cutoff date is——

Chairman MURKOWSKI. Well, is there any problem——

Mr. SHASTEEN [continuing]. Set in the law; isn't that correct?

Chairman **Murkowski** [continuing]. Putting that on legislative agenda?

It just seems to me that the name of the game is to try and make them eligible for whatever jobs are available. If we need a legislative correction here, let's do it.

All right?

Now, you say you have 280,000 veterans eligible, but you only have 30,000-some-odd jobs, and I assume that's why better than 90 percent of the veterans have been unable to use the program; is that right?

Mr. **Shasteen**. Yes, that's part of the reason. We have about 93,000 job slots that are available, and we're in the process of matching—as long as the funds continue, of matching the veterans who are eligible with the jobs that have been approved.

Chairman **Murkowski**. Well, OK. What, in your opinion, is, from your standpoint, as the Administrator, the key problem? What it would take? With a program that's only getting 10 percent utilization, in the sense of veterans being placed in jobs, what tools do you need to make the funding go to get the jobs? Because that's what we're looking for.

Mr. **Shasteen**. Well, part of it is the coordination that we need between our agency and the positions we fund at the local Job Service level, coordination with the Veterans' Administration and the various programs it administers.

Chairman **Murkowski**. You're implying that there is not enough coordination between you and the Veterans' Administration?

Is that right?

Mr. **Shasteen**. We are constantly working at that, and we are improving it. And we have, I think, good coordination, but takes a while to make the match.

First of all, on average, an employer, before he hires someone, will receive three, four, or five persons to be considered for a position that's available.

That takes time.

Second, in the case of the veterans, it's very important that we make certain they're job ready before they're referred.

If a veteran is not job ready, then we consult with the Veterans' Administration and find whatever assistance that veteran might need, through VA programs and through other community services, for the veteran to become job ready.

Chairman **Murkowski**. Well, do you need any tools, legislatively, that would help you?

We've already talked about trying to do something here to extend the deadline.

And you're saying you've got some problems of coordination.

It seems like one is constantly aware of the disparity between the job market, which may be on the west coast of the United States, and the high unemployment, which may be in the Northeast industrial area.

Is that part of your problem?

Mr. **Shasteen**. That's part of the problem, but we—we really don't see that we need any more tools.

What's happening is that it is taking time, it has taken time, for employers to accept this program and to sign up for it and become interested in it. And now the program is really rolling.

It started out rather slowly—in the first 2 or 3 months—it's really rolling now.

Chairman **Murkowski**. If you could do two or three things, what would you want to do most to make it work better? Because in spite of the fact that I agree with you, it's off to a start, we've still got 10 percent of those that applied that have been placed in jobs.

Mr. **Shasteen**. Well, our—I think more than anything else we need to increase our contact with the Job Service——

Chairman **Murkowski**. Well, can't public service programs help you in those areas? Television stations are dying to help you out, because they're getting looked at for other advertising programs that they're being criticized for, and they want to do some public service work.

Mr. **Shasteen**. We——

Chairman **Murkowski**. Do you have a program in that area?

Mr. **Shasteen**. Yes, sir, we do have. We have——

Chairman **Murkowski**. Can you——

Mr. **Shasteen** [continuing]. Called upon the television stations. We've supplied them with public service announcements—two series of them, as a matter of fact.

We have now allocated part of our public information outreach funds to the regions and States for them to devise local outreach efforts through the media, to reach veterans and employers, to bring the two together.

Chairman **Murkowski**. Do you communicate with veterans' organizations and get their input on what they might suggest you do?

Mr. **Shasteen**. Yes, sir, we do, on a regular basis.

We also communicate through the Secretary's Committee for Veterans' Employment, which is mandated to meet quarterly.

Chairman **Murkowski**. Well, I don't know your business, and I'm not supposed to. But if you have any specific suggestions that the Congress might address with regard to assistance and how you handle the coordination between the Veterans' Administration, as well as reaching out to the private sector, we would be happy to assist.

Mr. **Shasteen**. We appreciate that, Mr. Chairman.

If this budget is approved, we feel that it will do the job that is expected of us and will enable us to continue—in fact, we're striving to increase our effectiveness in placements through the Emergency Program and all other programs that we administer for veterans—targeted jobs tax credits, for example.

Chairman **Murkowski**. Senator Matsunaga.

Senator **Matsunaga**. Thank you, Mr. Chairman.

Now, under the proposed budget, will you be able to effect—to operate as effectively as you have in the last fiscal year?

Mr. **Shasteen**. Yes, sir; we believe that we will be able to do that.

Senator **Matsunaga**. That's remarkable.

That's—and even with the projected increase in the work load?

Mr. **Shasteen**. We are endeavoring—as we gain—we're a relatively new agency, we're gaining experience all the time. We've acquired some very experienced people from the Employment and Training Administration. We're increasing productivity. We have right now, among the States, competition that's taking place to increase the placement of veterans during the current 6-month period, compared with the same period 1 year ago. A year ago, in 1 year's time, we were putting about 500,000 veterans into jobs in 1 year. We're trying to increase that to the rate of 550,000 per year. That's our first goal.

Once we reach a goal, we regard that as a plateau, and we set a new goal and strive for that.

Senator **Matsunaga**. I'm not familiar at all with your Job Training Program. How do you operate in that respect?

Mr. **Shasteen**. Well, we have relatively few funds under the Job Training Partnership Act, which we have allocated in two ways: 80 percent we allocate to the States—we offer to the Governor and the service delivery areas to submit proposals to us to compete for those funds. The other 20 percent, we advertise for proposals for national programs that we hope will serve as demonstration projects.

We have advertised two of those proposals in recent months, one for Hispanic veterans and another for black veterans.

Senator **Matsunaga**. In providing funds to the States, do you set up certain minimum standards? And who determines what those minimum standards should be?

Mr. **Shasteen**. We do have criteria, in the nature of specifications. And we ask them—we don't try to make them too restrictive, because we like to have the States use their initiative and their imagination and come in with the proposal or proposals that they feel will serve the largest number of veterans in the most effective way.

Senator **Matsunaga**. Yes.

Mr. **Shasteen**. We do have some competition for that. We've made a total of about 65 grants so far.

Senator **Matsunaga**. And then, from your statement, I take it that you're fully satisfied with the progress your agency has made?

Mr. **Shasteen**. Well, with the progress that we've made to date, with one exception, I've—I grew up in the State of Colorado, and I remember reading, on the top of the Denver Post every day, "There is no hope for the satisfied man."

So, my feeling is that, yes, we can do more, and we can do better. And we're going to do that with this budget.

Senator **Matsunaga**. So that you are satisfied with what you are doing now, but not satisfied with what you can do tomorrow?

Mr. **Shasteen**. That's right.

I'm convinced we can do more and we can do it better.

Senator **Matsunaga**. OK.

And—well, let's hope the veterans feel the same way. We'll find out after you're through. [Laughter.]

Mr. **Shasteen**. That's right.

Well, they've been—I must say they have been—veterans' organizations have been very helpful to us.

Senator **Matsunaga**. Mr. Chairman, I have to go to another meeting. And I regret very much that I may not be here to listen to the veterans' groups, but I wish to assure them that I will be reading their written statements and perhaps followup with written questions if necessary.

Chairman **Murkowski**. Thank you, Senator Matsunaga.

Senator **Matsunaga**. I apologize for having to leave now.

Chairman **Murkowski**. I think we have heard some rather remarkable and enlightening testimony here from the panels.

It was indicated that the response to some of the problems isn't necessarily to throw money at it, as was proposed by Dr. Ditzler. He was stating that the $12.5 million that they didn't ask for was, in actuality, because they had a good program and it was going along well. We've heard Don Shasteen indicate that he felt he had the expertise because of certain efficiencies to do the job without additional funding.

We will now call on Senator Cranston, who, I am sure, has some questions.

Senator **Cranston**. Don, I will submit one question to you in writing.

I do want to say that I think your budget request is basically very sound, and I am grateful to you for submitting such a very good one.

Mr. **Shasteen**. Thank you very much.

Senator **Cranston**. Thank you, again.

[The response of the Department of Labor to a written question submitted by Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follows:]

RESPONSE OF THE DEPARTMENT OF LABOR TO A WRITTEN QUESTION SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question.

Don, at page 5-99 of the President's budget for Fiscal Year 1986, in connection with the discussion pertaining to Federal-State Employment Services, it is noted that the Administration intends to "Develop and propose legislation to devolve to the States the responsibility for managing and financing their employment services and unemployment services." It is further noted: "Certain employment services designed to meet national needs would continue to be financed with grants under specific agreements with the States. National activities to be financed in 1986, include special services to veterans..."

It is unclear to me from this discussion what effect, if any, this approach would have after FY 1986, on services provided by Local Veterans Employment Representatives and Disabled Veterans Outreach Program Specialists.

A. Could you briefly explain what the impact of the Administration's plan would be on those two programs and on the Veterans' Employment and Training Service itself?

B. Please provide additional details, For the Record, of the effect of this proposal on all Labor Department-Financed Veterans' Employment activities.

Answer.

The specifics of the Administration's proposal to devolve to the States the responsibility for managing and financing their employment and unemployment services have not been developed. Until such time as I have more information I will be unable to respond to this question. Be assured that I will continue to advise the Secretary of any operational or administrative problems that would adversely affect services to veterans.

Senator **Cranston**. If we could have Mr. Walters come back.

Chairman **Murkowski**. There he is.

Senator **Cranston**. Yes.

Chairman **Murkowski**. I'm going to excuse the panel, in order to accommodate Senator Cranston.

Is it necessary, Senator Cranston, that any of the other panel members be here, or is it adequate to have just Harry Walters?

Senator **Cranston**. If we could just have Dr. Ditzler and Mr. O'Toole, and Mr. Bannai——

Chairman **Murkowski**. I see. Well, we will call in——

Senator **Cranston** [continuing]. If they're here.

Chairman **Murkowski** [continuing]. The entire panel, because we wouldn't want Mr. Alvarez to feel left out.

Senator **Cranston**. All right. [Laughter.]

Mr. **Walters**. They got away.

Chairman **Murkowski**. They got away.

Senator **Cranston**. OK.

Chairman **Murkowski**. So, all you've got is—no? Well, Dr. Ditzler is here.

The seats are warm, gentlemen. Why don't you come on back?

And we will quickly show the efficiency of the staff by changing the signs.

You don't have them any more?

They lost their names, so you're out of luck.

Senator **Cranston**. How are we going to know which is which?

Chairman **Murkowski**. I don't know. You've been here longer than I have. [Laughter.]

[Veterans' Administration's testimony resumed.]

Senator **Cranston**. Harry, I note that you have proposed, in your fiscal year 1986 request, the appropriation of $6 million for the purposes of land purchase for a new national cemetery in northern California.

One of the parcels of land under consideration by the VA is a 150-acre parcel at the Army's Camp Parks in Alameda County.

Is it correct that unless a waiver is granted the VA would have to pay to the GSA the fair market value of that land?

And is this the parcel of land for which you've requested the appropriation of $6 million?

Mr. **Walters**. The answer is yes to both questions.

Senator **Cranston**. Are you aware, then, that the Alameda County Public Works Department has estimated that the value of that parcel is somewhere between $13 and $22 million?

Mr. **Walters**. I was not aware of that, Senator.

Senator **Cranston**. I think that should be looked into, then. I assume you will.

Mr. **Walters**. Yes; I will.

Senator **Cranston**. I previously urged you, specifically in a February 4 letter, to accept the gift at no cost to the Government of a parcel of land in Santa Nella, CA, for the purposes of building the new VA cemetery in northern California. As I stressed in that letter, when the comparison is made between that location and the only other apparently available location, the Camp Parks site, the Santa Nella site is clearly the more suitable location.

The Santa Nella site is vastly superior, in terms of esthetics and surrounding land uses, has more than twice the acreage, and has the official support of the California Department Commanders' Veterans Council.

Also, the Camp Parks site is opposed by the affected communities, both the county of Alameda and the city of Dublin.

In light of these facts, why would it make sense for the VA to spend $6 million or more to acquire land for a new cemetery when very suitable land is available at no cost to the Government and to the taxpayers?

Mr. WALTERS. It may make no sense whatsoever. I've asked Paul Bannai, Director of Memorial Affairs, to look into that entire matter and we should have some kind of analysis available to you in the not-too-distant future.

Senator CRANSTON. Fine. I appreciate that very much.

I don't see any way that I could support the appropriation of $6 million if the other site is as suitable as I believe it is and if it's available without cost.

I'm sure we can put that construction money to much better use, such as a new design for a replacement hospital at Baltimore—the existing plans are now about 8 years old, I think—or to increase funding for grants to States for State home nursing beds.

Mr. Chairman, I ask unanimous consent that my February 4 letter to the Administrator on this matter be printed in the hearing record at this point.

Chairman MURKOWSKI. Without objection.

[The letter referred to above follows:]

ALAN K. SIMPSON, WY, CHAIRMAN
STROM THURMOND, SC
ROBERT T. STAFFORD, VT
FRANK H. MURKOWSKI, AK
ARLEN SPECTER, PA
JEREMIAH DENTON, AL
RUDY BOSCHWITZ, MN
ALAN CRANSTON, CA
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GEORGE J. MITCHELL, ME
ANTHONY J. PRINCIPI, CHIEF COUNSEL/STAFF DIRECTOR
JONATHAN R. STEINBERG, MINORITY CHIEF COUNSEL/
STAFF DIRECTOR

United States Senate

COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

February 4, 1985

Honorable Harry Walters
Administrator of Veterans' Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry,

For some time now, I have been following with great interest the VA's efforts to establish a new national cemetery in Northern California. I am pleased that the VA has recognized the great need for a cemetery in that area and is exploring available options. In that connection, I asked a minority staff member of the Senate Veterans' Affairs Committee to make an on-site visit to the various parcels of land presently identified as possible locations for the new cemetery -- specifically, the 150-acre parcel at Camp Parks and the 400-acre parcel at Santa Nella -- and discuss with interested parties their concerns regarding the potential sites.

On the basis of that visit and those discussions, I have concluded that the 400-acre parcel proposed to be donated to the VA in the Santa Nella area is clearly the more suitable selection. First, the Santa Nella site is vastly superior in terms of aesthetics and the compatible uses being made of the surrounding lands. Placing the cemetery in the Camp Parks area would mean that it would be adjacent to two correctional facilities, quite near major road and public transportation congestion, and in the middle of a well-populated area that is developing into an industrial/transportation park. The Santa Nella site, on the other hand, is situated near the San Luis Reservoir in low-density development and adjacent to land dedicated to wildlife preservation and agricultural use.

Second, both the County of Alameda and the City of Dublin oppose the establishment of a national cemetery at the Camp Parks site. Although the County and the City are not in accord on the manner in which this parcel might best be developed, neither believes that establishment of a national cemetery constitutes the "highest and best use" of the land. In the event that the Camp Parks land is released by the Department of the Army and made available to an entity other than the Federal Government, the County's and City's long-range planning preferences are that the land be used for industrially- and/or transit-oriented purposes.

Third, unlike the Camp Parks land -- for which the VA would, unless a waiver is granted, have to pay fair market value to the General Services Administration -- the Santa Nella site is available to the VA free of charge. As you know, the Romero Ranch Company has offered to donate the parcel to the VA for the purposes of establishing the new cemetery.

Fourth, the California Department Commanders Veterans Council has officially endorsed the Santa Nella site and objected to the Camp Parks site.

Fifth, the considerably greater available acreage at Santa Nella --400 acres as compared to 150 acres -- means that the needs of Northern California's veterans could be met for a much longer period of time if that location were selected.

I fully recognize that the Santa Nella site is not as convenient to the downtown San Francisco area as the Camp Parks site. However, I believe it is reasonably accessible to the Bay Area and note that a non-rush-hour car-ride from Santa Nella to San Jose takes only about an hour and a half and to the San Francisco-Oakland Bay Bridge only two hours. In addition, as population growth continues to move further and further south and east from the San Francisco area, the distance to Santa Nella diminishes for more and more veterans' families. In this connection, I note that the Center for Continuing Study of the California Economy in Palo Alto, California, has determined that, among large cities in California, San Jose ranks third in total population growth since 1980. Furthermore, the Santa Nella site is convenient to other centers of population growth in the State, including Fresno and Modesto, which were ranked fourth and eighth, respectively, in terms of percentage increase in population growth since 1980.

There is, as you know, Harry, a pressing need to move forward on the establishment of a new national cemetery in Northern California. Thus, I strongly urge you to proceed as rapidly as possible with plans to locate the new national cemetery at the Santa Nella site.

With warm regards,

Cordially,

Alan

Alan Cranston
Ranking Minority Member

cc: Honorable Tony Coelho
Honorable Ron Dellums
Honorable Frank Murkowski
Honorable G. V. (Sonny) Montgomery
Honorable John Paul Hammerschmidt
Mr. Paul Bannai

Senator CRANSTON. In Ronald Reagan's first budget when he assumed the presidency, the fiscal year 1982 revised budget, he proposed that the VA achieve savings of $49.4 million and 1,673 FTEE's in that year by consolidating its regional offices into three offices. The Congress flatly rejected that proposal.

Now, almost exactly 4 years later, we're again told that the VA plans to pursue that specific consolidation approach.

As you know, one of the outcomes of the proposal made in 1981 was the enactment of legislation—specifically section 210(b)(2) of title 38, United States Code—designed to prohibit the VA from acting on such an administrative reorganization without having first given the Congress an opportunity to review in detail the plan and justification for it.

I've already stated to you, in my letter of February 8 that I believe that the document you presented to the Congress on February 1 doesn't meet the criteria set forth in section 210(b)(2), and that thus the proposed consolidation could not lawfully be initiated in fiscal year 1986.

When can I get a response to that February 8 letter?

Mr. WALTERS. Well, is the acting general counsel still here?

Mr. COY. Yes.

Mr. WALTERS. Bob, would you want to address that? It's a legal matter, and I think you've been researching that.

Mr. COY. Yes, sir.

Senator, we have taken a look at your request and have just about finalized an opinion. You did request a formal opinion. We want to submit that to the Administrator.

Obviously, that's a difficult issue, and a requirement is in the law for a detailed analysis. The notice was not as detailed as we would have liked it, as the Administrator indicated, because of the shortness of time. We did believe, however, that the 9-month process does provide a perfecting period, whereby if additional studies, as the Administrator indicated would take place, do come up with new information, that would be shared with the Congress, and then we would act together to take the appropriate action.

Senator CRANSTON. The law says there should be a detailed plan and justification by the date that the plan is submitted.

But at any rate, in the letter, I asked you to—I asked you, in the letter I wrote, to request a General Counsel's opinion as to whether your February 1 letter satisfied the advanced notice requirements of section 210(b)(2).

I'm glad to know that such an opinion has been requested. When will it be finished?

Mr. COY. That opinion will be finalized this week, and it can be submitted for the record.

Senator CRANSTON. I ask unanimous consent that the VA's February 1 letter, my February 8 letter, and any VA response to my letter be printed in the hearing record at this point, also, Mr. Chairman.

Chairman MURKOWSKI. Thank you.

[The letters referred to above follow:]

Office of the
Administrator
of Veterans Affairs

Washington, D.C. 20420

Veterans
Administration

FEB -4 REC'D

FEBRUARY 1- 1985

Honorable Alan Cranston
United States Senate
Washington, DC 20510

Dear Senator Cranston:

In accordance with the provisions of Title 38 United States Code, Section 210(b)(2), we are providing notification of a planned reorganization and consolidation of field office functions of the Department of Veterans Benefits (DVB), that do not require face-to-face contact with the veteran.

JUSTIFICATION

Consolidation of these functions will enable us to take better advantage of the advances of recent years in management and communications technology. In this way, we can further improve our efficiency in delivering veterans' benefits and provide for continued high quality service to veterans. This change will enable employment to be reduced by 17 percent over 1986-88. In addition, after the consolidation is complete, substantial budget savings will be achieved.

PLAN

We propose to consolidate DVB benefit processing and support activities from 59 regional offices into 3 processing centers over the course of fiscal years 1986 through 1988. Activities designated for centralization include adjudication of compensation, pension, and education claims; loan processing; and support services, including administrative, finance, and personnel functions.

DVB operations involving direct personal contact with veterans and beneficiaries will continue in the regional offices, and no office would be closed by this consolidation. Veterans assistance, compliance survey, vocational rehabilitation and counseling, and loan servicing, property management, and construction and valuation activities will remain at the field offices.

DVB employment would be reduced by more than 2,300 FTEE over the three years as a result of efficiencies possible with consolidation. Current budgeted staffing for FY 1985 is 13,518. A reduction of 624 FTEE is scheduled for FY 1986. Employment reductions will be accomplished through centralization of the designated functions. Staffing reductions will be achieved through attrition, voluntary reassignments, and special initiatives for employee placement.

Annual savings of more than $55 million can be realized after full implementation of the planned consolidation. However, one-time costs for relocation and severance pay, as well as site preparation and equipment, will require approximately $85 million over the next three years. The 1986 President's Budget contains $25 million for the 1986 consolidation, and the remainder of the $85 million has been included in the projections for 1987 and 1988.

Reorganization will be achieved by transferring the designated activities to the three center locations through a transfer of function. Between 7,800 and 7,900 FTEE would be affected. We will meet all labor-management obligations, including the requirement to provide 120-day notice to the American Federation of Government Employees (AFGE) and the National Federation of Federal Employees (NFFE).

A task force has been established to develop an implementation plan by July 1985. The task force will provide definitive plans on locations and relocation strategies, as well as detailed estimates on translocation and equipment costs (particularly for ADP equipment).

To allow for the lead time required to prepare office space, we now expect the first move to occur in July 1986.

I will be pleased to provide any additional information you may desire regarding our plans for consolidation and reorganization.

Sincerely,

Harry N. Walters

HARRY N. WALTERS
Administrator

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

February 8, 1985

Honorable Harry N. Walters
Administrator of Veterans' Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry,

I am writing in response to your February 1, 1985, letter regarding a planned reorganization and consolidation of certain field office functions of the Department of Veterans' Benefits. In that letter, you stated that you "propose to consolidate DVB benefit processing and support activities from 59 regional offices into 3 processing centers over the course of fiscal years 1986 through 1988."

I share with you a strong desire to improve the efficiency of VA operations and the quality of services. I also believe that the VA should make a concerted effort to take advantage of recent advances in communications and data processing technology in order to make such improvements. However, any actions taken in pursuit of the goal of greater efficiency must, I'm sure you will agree, not be at the expense of service to veterans and be carried out in full compliance with the law.

In your February 1 letter, you stated that you were providing notification "[i]n accordance with" section 210(b)(2) of title 38, United States Code. For the reasons discussed below, I believe that your letter fails to meet the requirements of section 210(b)(2) and that this law prohibits action to implement the planned reorganization during FY 1986.

Under the pertinent provisions of section 210(b)(2), you "may not in any fiscal year implement" a reorganization involving a more-than-10-percent reduction in the number of full-time equivalent employees (FTEE's) at any VA facility with more than 25 employees unless you first submit, not later than the date on which the President submits the budget for that year, to the appropriate Congressional committees "a report containing a detailed plan and justification for the ... reorganization." In my view, your letter falls far short of providing the type of "detailed plan and justification" required by the law. For example, the letter does not even indicate the number of employees who would be moved (either in total or from each regional office) or identify the cities at which the 3 processing centers would be located. Nor does the letter state how the consolidation would make the estimated more than 2,300 FTEE-reduction possible other than through a vague and conclusory reference to "efficiencies possible with consolidation", which I do not view as satisfying section 210(b)(2).

Moreover, the letter was totally ambiguous as to whether employees who adjudicate claims and attend hearings requested by claimants would remain in the regional offices. Your letter said both that claims adjudication activities would be centralized and that "operations involving direct personal contact with veterans and beneficiaries" would not be moved. This raises the question whether the adjudication personnel whose duties involve direct personal contact with veteran-claimants, such as conducting hearings, would or would not be moved.

These and many other questions would have to be specifically addressed in any type of "detailed plan" in my judgment.

I believe that your letter also fails to provide a "detailed ... justification". The mere recitation in the letter of claims that the reorganization would enable you to take advantage of recent technological advances, improve efficiency, and achieve savings is unsatisfactory.

In contrast, I note your letters, also dated February 1, 1985, regarding two other proposed reorganizations: the proposed closing of the three data processing and telecommunications field stations and the transfer of certain functions from the VA Prosthetics Center in New York City to a new Prosthetics Assessment and Information Center (PAIC) in the Washington, D.C., area. Both of these letters set forth in much greater detail the specifics of the proposed, much more limited reorganizations (whether or not the data processing letter contains a "detailed ... justification" as required by the law is an open question in my mind). Indeed, in the case of the proposed PAIC, the letter is accompanied by a description of the implementation actions and a summary of the proposal that discusses justification, organization impact, personnel impact, and fiscal and related impacts.

Indeed, you seem to recognize in the letter on the proposed DVB reorganization that you have not provided the requisite plan. You state that a "task force has been established to develop an implementation plan" and that, in July of this year, this "task force" will provide definitive plans on locations and relocation strategies, as well as detailed estimates on translocation and equipment costs ...." It may be that that plan, if accompanied by specific information justifying the reorganization, would provide the level and kind of detail required.

If such a plan and justification is submitted this year (or any time prior to or concurrent with submission of the President's FY 1987 budget), actions to implement the reorganization could lawfully be initiated in FY 1987.

In light of the extensive work that would be necessary to acquire and prepare the office space at the 3 centers, I would also like to emphasize the prohibition in section 210(b)(2) against any "action to carry out" a reorganization until the beginning of the fiscal year with respect to which adequate notification is given. In my view, the law applies not apply only to the transfer and attrition of personnel but also to all actions preparatory to the personnel moves that would be taken pursuant to the plan. Thus, even assuming that the July 1985 notification of this proposed reorganization will meet the law's reporting requirement, I believe that no work may be done or expenditures incurred to implement the reorganization plan until October 1, 1986, the first day of fiscal year 1987.

As you know, Harry, this reorganization proposal is of great interest and deep concern to many veterans, VA employees, and their families and to all members of the House and Senate. Therefore, I would very much like to learn as quickly as possible your responses to the issues I have raised. In addition, I request that you seek a formal written opinion from your General Counsel as to whether your February 1, 1985, letters regarding the proposed DVB reorganization and the closing of three data processing and telecommunications field stations comply with section 210(b)(2) as to an October 1, 1985, implementation date.

As always, I very much appreciate your cooperation and look forward to your prompt reply.

With best personal regards,

Cordially,

Alan Cranston
Ranking Minority Member

cc: Honorable Frank H. Murkowski
Honorable G.V. (Sonny) Montgomery
Honorable John Paul Hammerschmidt

Office of the
Administrator
of Veterans Affairs
Washington, D.C. 20420

Veterans
Administration

MAR 19 REC'D

MAR 12 1985

Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Senator ~~Cranston~~: Alan

Thank you for your letter of February 8 concerning our reported reorganizations of the Department of Veterans Benefits (DVB) and the Office of Data Management and Telecommunications (ODM&T). You raise a number of matters regarding these proposed reorganizations.

As you requested, I have solicited an opinion from our General Counsel regarding the question of the adequacy of our February 1 letter reporting the proposed DVB and ODM&T reorganizations. A copy of that opinion is enclosed.

No final decision has been made as to the specific DVB consolidation proposal. It has been agreed that the Veterans Administration will develop a plan for modernizing its entire operations, and that we will consider various efficiency alternatives, one of which may be DVB consolidation. The DVB effort has just begun however, and, when it is completed, a decision will be made as to the best course of action to be taken concerning DVB. I want to assure you that we will, as always, work closely with you through our oversight committees, and with veterans' organizations to achieve a consensus before proceeding. We do believe that the ODM&T reorganization is appropriate. We will be providing you with additional specifics concerning it, and the DVB proposal.

I am sure that you would agree with the Administration's position that there is, today, an urgent need to work with the Congress to find ways to achieve savings in all Federal programs. We will attempt to do our part. However, while management improvements and greater efficiency can be realized in VA programs, I want to assure you that this will never be done, while I am the Administrator, by sacrificing compassionate, timely, and good quality care and services for our Nation's veterans.

Sincerely,

Harry

HARRY N. WALTERS
Administrator

Enclosure

Veterans Administration

Memorandum

FEB 20 1985

To Administrator (00)

From Acting General Counsel (02)

Subj Request for our Opinion as to the Legal Sufficiency of the VA's 2/1/85 Letters to Congress Reporting Planned DVB and ODM&T Reorganizations Under 38 U.S.C. § 210(b)(2)

1. The attached letters dated February 1, 1985 reported to appropriate VA oversight committees and subcommittees in the Congress two planned VA administrative reorganizations. One letter concerned the planned DVB consolidation of certain functions from 59 regional offices into 3 processing centers. The second reported the plan to close three ODM&T field stations and transfer their functions to two other VA Data Processing Centers. You request our opinion as to whether these two report letters were sufficient to meet the notice requirements of 38 U.S.C. § 210(b)(2). A second, related question is what kinds of VA activity constitute "implementation," or "actions to carry out" a reorganization, since such activity must be delayed under 38 U.S.C. § 210(b)(2)(A) until the first day of the fiscal year for which the reorganization is reported.

2. Section 210(b)(2)(A) of title 38, U.S. Code requires the VA to submit a "detailed plan and justification" to appropriate committees of Congress for certain planned VA administrative reorganizations. The first issue presented by your request is what degree of specificity must such a plan and justification meet in order to comply with this standard. The terms of the clause are not defined in the statute. It must be acknowledged, however, that the meaning of the term "detailed" is somewhat subjective and is an area where reasonable minds may differ.

3. The legislative history of this provision does not provide a definition as to the standard of specificity or description therefor. This provision was adopted as a Congressional response to an Agency reorganization involving DVB. In that proposal, substantially all DVB regional office functions would have been consolidated into approximately three offices. One of the two subject reorganizations would similarly consolidate significant portions of the local regional offices. It is noteworthy that Congress, in responding to the earlier plan, did not prohibit such a consolidation of DVB, but rather imposed the

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notice and wait requirement on any future such reorganization plans, such as the one which is a subject of this opinion. Thus, it is apparent that Congress did not intend to block significant reorganizations so much as to gain time to learn of and evaluate such proposed Agency action.

4. Taken together, the language of the statute, the legislative history and the events giving rise to this legislation, it may be concluded that the subject clause requires that any such report of a planned reorganization provide notice sufficient to enable the Congress to effectively and efficiently mount its own fact finding and evaluative efforts regarding the planned reorganization so as to make its own assessment of whether to attempt to block such action by legislative means. This provision establishes a period of time in which Congress is assured of several months for fact finding, evaluation and effecting a legislative response. Thus, while the statute uses the word "detailed," the degree of specificity must be considered in the context of the overall process.

5. It is quite clear that once a report provides notice to Congress of a proposed plan the VA oversight committees have the experience and resources to closely scrutinize, question, and if necessary block any proposed reorganization. Such oversight is effected regularly and effectively in all VA program and budget areas by the VA committees. This effectiveness is amplified by the "work together" and openness attitude which characterizes the VA's relationship with these committees. This significant, effective oversight process by the VA committees, fully available to them during the lengthy consideration period following submission of [illegible]ion plan, [illegible] be considered in calculating the degree of specificity required by the "detailed plan" requirement of section 210(h)(2)(A). The absence of definition of a standard here, coupled with the lengthy waiting period, underlines further the clear intent that much fact finding would ensue following provision of notice of a planned reorganization. Between antagonists, the requirement for a "detailed" plan might never be satisfied. The fact that there is no statutory resolution mechanism in such an event suggests the intent, born of lengthy experience between the VA oversight committees and the VA, that whatever details may be lacking at the outset would be filled in sufficiently for the oversight committees to make a reasonable judgment on the desirability of a reorganization.

6. The conclusion then, is that while the Agency has a duty under section 210(b)(2)(A) to provide a "detailed," report on any significant VA reorganization, the absence of all of the details, should not, given the context of the Congressional evaluation oversight process established by this section, render invalid a report which, in other circumstances, might fail to meet commonly-accepted standards of what constitutes a "detailed" plan.

7. Applying the foregoing to the subject DVB report, it must be conceded that considerable detail is lacking; that substantive discussions of how much FTEE will be affected, or, how particular, critical affected activities would be administered following reorganization would contribute significantly to the understanding of what is proposed. On the other hand, the Agency stands ready to provide more information as that information is obtained. It is noted that the Agency letter admits that the VA lacks some details regarding the DVB plan. The Agency has given notice of its basic objective. There is no doubt as to the overall intended result. The Agency will be obliged to provide additional information regarding this reorganization plan, however, to enable the oversight committees to evaluate it properly.

8. Although not of great length, the ODM&T submission provides somewhat greater detail, and, when considered in light of the whole process, seems to meet the submission requirement of the subject section.

9. The second question is what kinds of VA action constitute "implementation" or "actions to carry out" a reorganization for purposes of the waiting period requirement. The words of 38 U.S.C. § 210(b)(2)(A) provide that the "Administrator may not . . . implement a covered administrative reorganization" until he first submits the required report, and further that "*[n]o action to carry out such reorganization* may be taken" after submission until the first day of the fiscal year for which the report was submitted. (Emphasis added.) Obviously, any complex VA reorganization involves a great deal of lead time and much activity ranging from early planning, to preparation for relocation of functions and personnel, to the actual execution of the reorganization with movement of people and equipment. Again, in the absence of a statutory or legislative history definition the purpose of the waiting period would appear to be the best guide to the intended meaning of the word "implementation." By providing for a lengthy waiting period, the Congress sought to preserve its option to "veto" a covered reorganization.

10. In light of this purpose, it would be inappropriate for the VA to obligate sizable government resources for a planned reorganization if, during the waiting period, it became reason-

ably apparent that the reorganization would be prohibited by the Congress. However, assuming compliance with the notice provision, we do not believe that the statute generally bars the Administrator from taking steps to commence the movement of personnel and equipment on the first day of the next fiscal year. Submission of such a report is an indication that an Administrator has already determined, in accordance with his statutory responsibilities, that serious pursuit of a reorganization may be in the best interests of program implementation and efficient management. Having made that determination he is obligated to proceed with planning and preparations, so as to permit any actual reorganization to be carried out as soon as possible, once the waiting period has expired. As indicated above, the commitment of resources predicated upon implementation of the plan must be tempered by continuing calculations of whether Congress will block the reorganization. But the fundamental duty of the Administrator to effect the correct management structure requires that prudent resource allocation be undertaken during the waiting period in order to realize the benefits of such reorganization as soon as possible.

11. Presumably, the Congress would only rarely take action to block a reorganization which the Administrator has determined would improve Agency management. Moreover, a measured VA commitment of resources is consistent with the statutory language itself. The language calls for the submission of information about the planned reorganization well before it could be implemented legally, and, contemplates the possible generation of extensive additional information during the oversight waiting period. Thus, the statute itself clearly contemplates that the Agency will expend resources to evaluate, continue evaluating and otherwise plan actual implementation of the reorganization, all before the date before which no actual implementation could take place.

12. Based upon the above, it is our opinion that VA "implementation" action which is prohibited during the waiting period under 38 U.S.C. § 210(b)(2)(A) is the actual carrying out of the reorganization with movement of people and equipment.

ROBERT E. COY

Attachments

Chairman **Murkowski**. I might add some of the soothsayers in the back have advised me that this detailed plan that's made reference to is not defined by law.

Is that correct, counselor?

Mr. **Coy**. That is correct.

The legislative history doesn't really explain what is meant by detailed, and so it's a case where, I suppose, reasonable minds would differ.

What we believe, however——

Chairman **Murkowski**. We have that all the time. [Laughter.]

Mr. **Coy** [continuing]. We believe that there is a 9-month waiting period before we proceed, in which it's intended that there be a sharing of information between the executive branch and the Congress. We're hopeful that the sharing of information, once it's obtained, will take place and could allow us to proceed if that's the way we decide to go.

Chairman **Murkowski**. Well, that might be a preview of your letter to Senator Cranston.

Mr. **Coy**. It could be. [Laughter.]

Senator **Cranston**. If that's a hint, I don't know how helpful it is. [Laughter.]

Chairman **Murkowski**. We do the best we can.

Senator **Cranston**. Yes. The matter will be resolved in court, in any event, I guess. So, we'll——

Chairman **Murkowski**. I'm sure it will. We have to keep the attorneys busy somehow.

Senator **Cranston**. Harry, do you personally favor the consolidation in the form presented in the budget?

Mr. **Walters**. Senator, in all honesty, I can't say I favor it or disfavor it.

It was thrust upon us rather quickly. And we're just not in a position to analyze that plan for its effectiveness in delivering veterans' benefits, both on a savings basis, as well as on a service basis.

Senator **Cranston**. Well, I know you'll look at it very carefully.

Mr. **Walters**. We will.

[Subsequently, the Veterans' Administration submitted the following information:]

The consolidation plan proposed in the 1986 budget differs from the one proposed in the 1982 budget. The 1986 consolidation proposal would consolidate some functions that do not require face-to-face contact with veterans into three offices, keeping all 59 regional offices open for business, while the earlier proposal would close regional offices.

Senator **Cranston**. In your prepared testimony, you make mention of a February 11 meeting you had with OMB regarding the development of a plan for modernizing the VA's entire operations and the consideration of various efficiency alternatives, including the consolidation of DVB.

You note that this is an effort that has just begun and that, when completed, "a decision will be made as to the best course of action to be taken concerning DVB."

Does that mean that the consolidation plan is off for now and that the VA is not, at this point, committed to proceeding with it?

Mr. **Walters**. No; it does not mean that. It means that the consolidation may, indeed, be an outcome of this modernization-driven study. I'm leaving it open, as an option as I think we should leave all options wide open.

Senator CRANSTON. In your answer to question three of my prehearing questions, you make what I consider to be the astonishing assertion that raising the loan guaranty fee from 1 to 5 percent would not reduce the number of projected loan originations.

Perhaps that is OMB's analysis. But is that also your analysis?

Mr. WALTERS. Well, I share some concerns as Senator Murkowski also has shared today about what this might do to the program.

I think the VA Home Loan Program is a very important basic feature of veterans' benefits. So, I think we've got to be at least aware of the fact and track what additional features are in the program to keep it funded. We cannot drop the program down to a level where it's no longer of great service to America's young veterans.

If I didn't have that kind of concern, I shouldn't be in this job. So, I do have that caution.

Since the 5-percent fee can be financed, the unique nondownpayment feature of the program will be preserved.

Senator CRANSTON. Well, you concede——

Mr. WALTERS. But we do have a shortfall as well.

Senator CRANSTON [continuing]. You concede there's a possibility that could be the consequence?

You're not predicting it would be, but you concede it might be?

Mr. WALTERS. It could be. That's conjecture.

Senator CRANSTON. Yes.

Mr. WALTERS. Yes, it could be.

Senator CRANSTON. I'd like to hear from the Director of the Loan Guaranty Services.

Is Mr. O'Toole here?

What is your view on this question of the relationship between a 5-percent fee and utilization?

Mr. O'TOOLE. I am sorry, Senator, what is that again?

Senator CRANSTON. What is your view on the matter of the relationship between a 5-percent fee and utilization?

Mr. O'TOOLE. We do not know what will happen to the utilization with that 5-percent fee. The early estimates are that it could reduce originations up to 50 percent, but that may be a little bit too high.

Senator CRANSTON. Could you provide for the record your thoughts?

Chairman MURKOWSKI. Senator Cranston, we have asked that for the record. They are going to. It was estimated in the testimony given earlier that it would be $29 a month more on an average mortgage of about $64,000. The question that I do not think that this committee can ask is, is that $29 a month going to basically create a situation where the veteran is not going to use the program, if indeed that 5 points is enacted.

Senator CRANSTON. Well, he just referred to an estimate that there might be a 50-percent drop, and that is the estimate that I would like to have submitted for the record.

Chairman MURKOWSKI. I would like to see that too.

Senator CRANSTON. So you will submit that for the record?

Mr. O'TOOLE. Yes, sir.

Senator **Cranston**. Thank you.

[Subsequently, the Veterans' Administration submitted the following information:]

VA has received numerous comments from real estate industry groups and veterans' organizations regarding VA's proposal to increase the funding fee. Based on these discussions, we believe loan activity could decrease by as much as 50 percent should the proposal be enacted.

Others in the administration have discussed this issue with housing finance experts who indicate that there would be no decline in loan activity. Because the 5-percent fee can be financed through the life of the loan and the program does not require the veteran to make a downpayment, the VA loan guarantee program would still be the only opportunity for a veteran with no equity to purchase a home.

Senator **Cranston**. You said in response to the chairman of the committee that the additional cost of a 5-percent fee, that is over the current 1-percent fee, would if financed would be about $30 a month on a $68,000 average loan for 30 years.

Is that correct?

Mr. **O'Toole**. That is right.

Senator **Cranston**. Then the average cost to the veteran would be $10,800 over the life of the loan, is that correct?

Mr. **O'Toole**. I will accept your figures on that, Senator.

Senator **Cranston**. I believe it is.

Mr. **O'Toole**. OK.

[Subsequently, the Veterans' Administration submitted the following information:]

The $10,800 cited by Senator Cranston is the sum of $30 payments over 30 years ($30 x 12 months x 30 years = $10,800). However, if this fee is paid upfront, at the veteran's option, it would amount to $3,400. Furthermore, $3,400 is the total 5-percent fee amount. Since a 1-percent fee is currently charged, the additional amount from this proposal is only 4 percent or $2,720.

Senator **Cranston**. Harry, could I get back to you.

Do you personally favor the proposed increase in the fee charged veterans for guaranteed loans?

Mr. **Walters**. I was asked that question this morning. And with caveats, yes, I think that we have a $400 million deficit in that program. I think that we need to look at it all. The 5-percent fee is OMB's best estimate as to what it is going to take to make up the deficit. And on that basis, I can approve of it.

If it is going to ruin the Home Loan Program, I do not think that anybody in this room wants to do that either. So I think that we have got to keep our eye on the ball. If you and the Congress decide to pass that 5-percent fee, then we need to make sure that it does not untrack the VA Loan Program.

Senator **Cranston**. Of course, if there is a 50-percent drop or anything close to that, you would not realize the proceeds that you would be counting on.

Mr. **Walters**. I do not think that I would have any choice about that, Senator Cranston. I think that I would be back in here pretty quickly to request some relief. If we had a 50-percent dropoff in the loan applications, that is an extensive amount of applications. It would be 100,000 loans.

Senator **Cranston**. Yes. But you then would not be receiving the fees that are being anticipated.

Mr. **Walters**. We would not be receiving the fees either, that is correct.

Chairman MURKOWSKI. You would not have foreclosures.

Senator CRANSTON. Yes.

Mr. WALTERS. We would not have as many foreclosures either.

Senator CRANSTON. You might have more foreclosures, as well. You cannot tell.

Mr. WALTERS. You are absolutely correct.

Senator CRANSTON. On a related point, Harry, do you personally favor Congress enacting legislation to preclude the surplus in the direct loan revolving fund scheduled to be more than $120,000 in fiscal 1986 from being available to reduce the projected shortfall in the loan guaranty revolving fund?

Mr. WALTERS. I have not dwelled on that issue, but I would be happy to give you my personal opinion on that for the record.

Senator CRANSTON. I would appreciate it.

[Subsequently, the Veterans' Administration submitted the following information:]

From a management perspective, the VA would prefer to continue to have the flexibility to transfer unused resources of the Direct Loan Fund to the Loan Guaranty Program. However, we understand that the Federal policy is that each fund be able to stand on its own.

Senator CRANSTON. On what date was it decided that DM&S did not in the current fiscal year need over 2,000 of the FTEE that Congress provided funding for in the fiscal year 1985 Appropriations Act, do you know when that decision was reached?

Mr. WALTERS. Dr. Ditzler, do you remember when that was?

Dr. DITZLER. It probably would have been January, but I cannot be specific to a date. It related to a review of the situation in view of the pass-back for the 1986 budget. And it also related to the amount of moneys requested in the supplemental.

Chairman MURKOWSKI. Senator Cranston, I wonder if you could finish your questions by prioritizing those that are left.

Senator CRANSTON. Sure.

Chairman MURKOWSKI. We have veterans' groups that have been here waiting since 1 o'clock. You could if you would like to submit any questions to the panel, and they of course will respond in writing.

Senator CRANSTON. Sure, fine.

Who made the decision in the agency?

Dr. DITZLER. Well, it was a complex decision made first in DM&S in conjunction with the Controller's Office. And it eventually passed up through the Administrator.

Senator CRANSTON. Was anyone at OMB or the White House involved in the decision?

Dr. DITZLER. Not in making the decision, no, only indirectly. And we made a management judgment based on the amount of moneys available.

Senator CRANSTON. Had there been an objection or an opinion expressed by either OMB or the White House?

Dr. DITZLER. No, this was our judgment based on the best way to handle the money that we had at hand.

Senator CRANSTON. The final question that I will ask because I do know that you have to move on to other witnesses. On page 4, Harry, of your statement, you mention that the fiscal year 1986 budget includes funds for the integrated hospital system ADP project.

How can spending $8.6 million for the IHS project in 1 year for ADP at only three hospitals be justified given the need for completing and approving the decentralized ADP program within DM&S at the other 169 hospitals?

Mr. **Walters**. Dr. Ditzler.

Dr. **Ditzler**. The three hospital system test was initiated years ago by Members of Congress as a test against our DHCP Program to see which of the systems is better. And this was to proceed for at least a 3-year period of time. And that is the amount of dollars required to complete the next year obligation.

Senator **Cranston**. In your judgment, is that a prudent expenditure given the restraints that we generally face on spending now?

Dr. **Ditzler**. Well, my personal opinion is that maybe 3 years ago it would have been "no". But today I think that it is a prudent opinion, because it is already in place and will provide a demonstration and cost comparison of what can be done as alternatives for the future.

Senator **Cranston**. I regret that we are not able to ask more questions. I will submit some in writing. I would appreciate an expeditious response. May I say one more thing just generally. That I am sorry that I will not be able to stay for the veterans' organizations' testimony. I do want to note that I found their testimony very helpful in preparing for this hearing. Many of the questions that I have asked of the VA and that I am submitting in writing directly reflect the concerns raised in the organizations testimony, and I am grateful to them for that help. And I thank you all very, very much.

Mr. **Walters**. Thank you, Senator.

Senator **Cranston**. Thank you, Mr. Chairman.

Chairman **Murkowski**. Thank you, Senator Cranston. The panel is excused.

Senator **Cranston**. Harry, thank you for staying.

Mr. **Walters**. Thank you.

[The responses of the Veterans' Administration to written questions, advance of hearing written questions, and written followup questions submitted by Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs; Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs; Hon. Dennis DeConcini, a U.S. Senator from the State of Arizona; and Hon. George J. Mitchell, a U.S. Senator from the State of Maine, follow:]

RESPONSE OF THE VETERANS' ADMINISTRATION TO THE WRITTEN QUESTIONS SUBMITTED BY HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. The Administration's FY 1986 budget indicates that legislation will be proposed for a 4.1% COLA for the VA compensation program at a cost of $342.8 million which would require a supplemental appropriation. The budget also proposes a 4.1% COLA for the VA pension program at a cost of $131.6 million, which is included in the budget request. If the Congress takes a position different from the Administration's proposed cost-of-living adjustments and, instead, supports a total freeze on COLAS, or a freeze on COLAS for non-needs-based programs, which approach would you favor? Please explain why.

Answer 1. We could not support a freeze on COLAS for non-needs-based programs. While service-connected disability compensation is not "needs-based," it is a payment that is made because the veteran's disability affects his or her earning power. The vast majority of the veterans with severe service-connected disabilities have little or no ability to provide for themselves and their families through their own efforts. It would be unjust to freeze the payments these veterans receive while increasing the pension received by veterans with nonservice-connected disabilities.

We also believe that, in light of the contributions already made to the national welfare by veterans, they should be asked to make the personal sacrifices a COLA freeze would entail only if the same sacrifice is asked of all other categories of Federal beneficiaries.

Question 2A. Will the 5% pay reduction for the Department of Veterans' Benefits only affect employee pay levels or will it be implemented by a reduction of the FTEE level?

Answer 2A. The Departments 1986 budget request reflects a reduction of $12,324,000 in payroll as a result of the proposed January 1986 5% pay cut. We do not plan to implement this reduction by reducing FTEE.

Question 2B. If implementation of the 5% pay reduction proposal will affect FTEE levels, what impact would this have on the Department of Veterans' Benefits and the level of service provided to veterans, in view of the fact that the Department of Veterans' Benefits is already projected to reduce its FTEE level by 624 during FY 1986?

Answer 2B. We do not intend to implement the 5% pay reduction by lowering FTEE. Therefore, no change in the level of service provided to veterans will occur as a result of the 5% pay cut.

Question 3A.

The VA budget books indicate that a task force has been established to study consolidation and will issue a report in July 1985 providing detailed consolidation plans and cost.

Please state the membership of the task force and the accomplishments and/or findings of the group to date.

Answer 3A.

Membership of the task force is comprised of the Directors of each Central Office Service and Staff.

The task force was originally established to study consolidation of VA Regional Offices and planned to issue a report in July 1985. However, prior to any action by the task force, the Administrator on February 11, met with OMB and reached an agreement to undertake a major effort to develop a plan for modernization of DVB field office functions. We have agreed to furnish a plan to OMB in mid-summer describing the options available for improving and modernizing DVB operations. McManis Associates, Inc, Management and Research Consultants have been contracted to assist in this effort.

Question 3B.

Since the report will not be issued for some time, what assumptions were used to formulate the FY 1986 budget request for the Department of Veterans' Benefits consolidation plan? Please provide specifics, including a breakdown of the $25.1 million requested in the FY 1986 budget to effect the consolidation plan.

Answer 3B.

The basic assumptions were:

- Consolidation will not eliminate any regional offices as only the personnel without direct contact with the veteran/survivor are affected.
- The Adjudication, loan processing, Administration, Finance, and personnel functions would be consolidated where applicable.
- Consolidation would begin in Fiscal Year 1986.
- Reductions would be achieved by attrition.

A breakout of the $25.1 million to effect consolidation is as follows:

Payroll	
Translocation/relocation	$10,054
Termination/severance	2,820
Non-Payroll	
Travel	1,274
Transportation of things (shipments)	1,250
Printing	70
Site Prep	500
Supplies	2,782
Equipment	6,350
	$25,100

Question 4.

A. Will the consolidation plan for Department of Veterans Benefits effectively utilize the existing Target System? If not, please indicate why not. If enhancements will be necessary, please describe any anticipated enhancements, including any related cost estimate.

B. Will funding be required to design and to install a new automation system to make the consolidation cost effective and efficient in the long run, and if so, what do you anticipate the costs to be?

Answer 4.

Consolidation will be considered as part of an overall VA modernization program. An integral part of this modernization program will be development of an ADP strategic plan which will consider the existing Target System as well as the latest developments in ADP equipment to insure the most modern and efficient benefits delivery system. The plan for the VA modernization program will include planned design, enhancement and/or replacement of ADP equipment together with cost estimates.

Question 5A. Please indicate the sites where regional offices are being colocated or considered for colocation on medical center sites.

Answer 5A. Listed below are those regional offices and medical centers being considered for colocation.

REGIONAL OFFICE	MEDICAL CENTER
Fargo	Fargo
Wichita	Wichita
New York	St. Albans, Brooklyn or Northport
Newark	East Orange
Reno	Reno
San Francisco	Palo Alto or Livermore
St. Paul	Minneapolis
Chicago	Hines
Des Moines	Des Moines or Knoxville
Los Angeles	Los Angeles
Winston-Salem	Salisbury
St. Petersburg	Bay Pines
Houston	Houston
Montgomery	Montgomery
Boston	Boston or Brockton
Detroit	Detroit or Allen Park
Hartford	Newington
Cleveland	Brecksville
Boise	Boise
Columbia	Columbia
Indianapolis	Indianapolis
Lincoln	Lincoln
Manchester	Manchester
Roanoke	Salem
St. Louis	St. Louis
Milwaukee	Wood (Colocation completed 1983)

However, on Feburary 11, 1985, the VA Administrator met with the Deputy OMB Director. At that time, it was agreed that VA would develop a plan for modernizing its entire operations and would consider various efficiency alternatives; i.e., DVB consolidation and/or colocations.

Question 5B. Please describe how the colocation sites were identified, including:

- the criteria used to select each regional office/medical center on the list;
- the reasons for the chronological selection/priority for each;
- the assumptions and justification for the number of colocations included for each year;

- the anticipated budgetary impact for each colocation project in the year of colocation, anticipated outyear savings, and anticipated impact on efficiency levels for each; and
- the projected completion date for each colocation project.

Answer 5B. In 1983, at the request of the Department of Veterans Benefits, the Department of Medicine and Surgery surveyed all medical centers to determine if suitable land for construction and/or buildings satisfactory for housing DVB activities were available. As a result of this survey, medical centers with available buildings or space were matched with appropriate regional office activities. A number of factors influenced decisions made in developing and prioritizing colocation. Of primary importance was the timeframe within which existing buildings could be made available for renovation or would become available as a result of new hospital construction. Next, we considered the problems encountered in existing space housing the regional office activity, including health and safety factors, working conditions, need for realignment or renovation to enhance operations, and any impending increase in Standard Level User Charges being assessed by GSA (General Services Administration). Another factor was overall cost to the Government; i.e., were we located in Federally-owned or leased property. The fact that a regional office activity was an organizational part of an existing medical center was also included in the many considerations.

It is stressed that the final determination as to whether to colocate must rest on those facts isolated by the completion of the cost comparison study required by OMB Circular A-104 and other budgetary considerations. To date, only three studies have been completed. Accordingly, the specific information requested is provided only for those stations.

FARGO AND WICHITA

Colocation of these two DVB regional offices to VA Medical Center grounds was given immediate priority. Space is available at both locations for construction of a DVB building. GSA has been advised of our interest in colocating and they expressed no objection to either relocation. Both are combined activities, that is, each is designated a VA Medical and Regional Office Center and both DVB and DM&S functions at these two stations report to a single director. Common services are provided in the areas of personnel, finance, and administrative support for both DVB and DM&S elements.

The activities were originally separated from their Center facilities to alleviate space deficiencies brought about by expanding medical related functions. Separation was the only alternative at that time. With GSA's assistance in 1979, the Fargo DVB elements were moved into an old post office building on an "as is" condition. The regional office activities at Wichita were relocated into a leased building (a vacant Sears and Roebuck retail store) in 1978.

Agency commitments have been made to Congressional and Senate representatives and to National Veterans Service Organization officials to return these two regional office activities to Center grounds as soon as new facilities can be constructed.

For both offices, the completed economic analysis required by OMB Circular A-104 favored construction of a new building to house DVB activities on medical center grounds. Projected costs are $4,646,000 for Fargo and $5,433,000 for Wichita. No beginning or completion dates can be projected due to future budgetary considerations.

HOUSTON

A colocation agreement was signed by the Chief Benefits Director and the Chief Medical Director on November 5, 1980. This agreement was based on fact that buildings to house DVB activities would be available upon completion of the replacement hospital. GSA was notified of our intent to relocate the office to medical center grounds and they voiced no objections as the space being occupied is not Federally owned. Thus, overall cost to the Government would be reduced.

An A-104 economic analysis has now been completed and the results favor colocation. However, based on the study, it would be more cost beneficial to build than renovate. No beginning or completion dates can be projected due to future budgetary considerations.

Question 5C. Please describe how the proposed Department of Veterans Benefits consolidation plan will be affected by this continued colocation of certain regional offices with medical centers.

Answer 5C. At this time, we have not determined the affect the proposed consolidation plan will have on colocation prospects. The Administrator has agreed to provide to OMB by mid-summer a plan for improvement and modernization of DVB field activities. At that time, we should be in a better position to accurately assess colocation prospects.

Question 6. What would the Veterans Administration save annually in GSA rental costs if all regional offices were colocated on sites of medical centers?

Answer 6. Approximately $49,001,000 would be saved annually in GSA rental costs based on FY 1985 estimates.

Question 6A. Please indicate the projected GSA leasing costs for FY 1986-1990 if no policy changes are implemented.

Answer 6A. The estimated GSA leasing costs to VA for FY 1986 - 1990 are:

FISCAL YEAR	AMOUNT
1986	$46,786,000
1987	50,961,000
1988	52,999,500
1989	55,119,500
1990	57,324,200

Question 6B. Please indicate the amounts which would be necessary for projected construction or alterations which might be necessary to accommodate the changes.

Answer 6B. At this time, we can not accurately project costs for colocating as each project is based on a different set of conditions. On completion of the economic analysis required by OMB Circular A-104 for each activity, projected figures will then be available. To date, A-104 studies have been completed for only three locations -- Wichita, Fargo and Houston.

Question 6C. Please indicate any other associated costs.

Answer 6C. Other associated costs include transportation/moving, utilities (telephone, electric, water, etc.), maintenance and guard service. These costs are also contingent on factors involved in the basic colocation decision process.

Question 7A.

It appears that the work measurement system currently used by the Department of Veterans Benefits (DVB) measures process but not outcome.

What are your views on the current system?

Answer 7A. My views concerning the DVB Work Measurement System were greatly influenced by comments received from OMB, GAO and the President's Private Sector Survey on the Cost Control. These views were that the DVB Work Measurement system used to develop staffing needs was just not convincing and lacked credibility.

Rather than allowing this situation to continue, I suggested that an independent private company be contracted to study this system to show all concerned that the VA wanted a system all could understand and rely upon to justify its needs to Congress, OMB and the American people.

Question 7B.

You have indicated that you would have the results of the Arthur Young study on the DVB work measurement system by March 1, or shortly thereafter.

- Please indicate the major strengths and weaknesses of the DVB work measurement system as identified by the study.

- What are your views on the findings and recommendations of the study?

- How will the recommendations of the Arthur Young study on the DVB's work measurement system be factored into any significant changes and improvements which will be implemented within the Department of Veterans Benefits. Please comment on what, if any, impact this will have upon current DVB staffing projections for FY 1986.

Answer 7B.

I have been briefed by the Arthur Young and Company team that conducted the study. I am following up that briefing with additional questions about the study. As soon as it is completed I will then be able to comment on the impact on the DVB staffing projections.

Question 8. In your statement before the Senate Veterans' Affairs Committee hearing on February 20, 1985, you stated that the VA has just begun an effort to develop a plan for modernizing its entire operations and will consider various efficiency alternatives, one of which will be the DVB consolidation. When the effort is completed, a decision will be made as to the best course of action to be taken concerning DVB.

Please describe the VA's "plan for modernizing the entire DVB operations," particularly with respect to consolidation within DVB, including, but not limited to: —

- scope of the plan;
- goals to be achieved;
- principal parties involved;
- areas of concentration;
- status of the plan and accomplishments to date;
- expected completion date; and
- interaction with and/or overlap with the task force established to study the DVB consolidation plan.

Answer 8. On February 15, 1985, the Administrator issued a management directive for modernizing automation and telecommunications systems in the VA. The directive proposes better service to the veteran through modernization and consists of six key guidelines:

1. Proposed changes are to be assessed from the vantage point of the veteran;

2. each employee must have appropriate on-line access to those data bases needed for his/her job;

3. systems and equipment must be designed for easy use by nontechnical personnel;

4. VA staff must be relieved of paperwork burdens; and

5. capitalize on experience of others in our planning efforts.

6. organizational roles must be better defined

This is an agency-wide directive to be implemented by all Departments and Staff Offices.

The Administrator met with the Deputy Director of OMB on February 11, 1985, to discuss the DVB consolidation requirement. OMB agreed to extend the timeframe for submission of a plan to implement consolidation until the modernization issue has been fully examined. The Administrator then charged the Acting Chief Benefits Director to form a team consisting of Central Office and field staff, concerned VA staff offices and an independent management consultant to "aggressively examine its operation in light of the Agency's modernization goal and the principles on which it is based." Formation of the task force will be completed by March 30. The function of the task force to study consolidation will be incorporated into the new task force's mission to avoid duplicative effort and assure a comprehensive analysis. Utilization of advanced ADP/telecommunications networks in field operations offers many advantages, consolidation being one possibility; however, consolidation without proper planning for appropriate technological support would almost certainly result in degradation of benefits delivery. The Administrator will deliver the findings to OMB in June 1985.

Question 9. In the Final Report on the Review of Veterans Life Insurance Program Costs, dated September 28, 1984, the Inspector General recommended that the Chief Benefits Director propose legislation to provide that no tax, fee or other monetary payment be imposed or collected by any state or territory on any premium paid for the insurance policy purchased under the Servicemen's Group Life Insurance (SGLI) program. The audit report stated that the SGLI certificate holders paid almost $3.4 million annually in state premium taxes and an aggregate of approximately $42.5 million in state premium taxes since the inception of the SGLI program. The Chief Benefits Director concurred with the findings and recommendation.

A. Was this recommendation considered in formulating the FY 1986 budget request?

- If not, please state the reasons why it was not considered; and
- If it was considered, what, if any, impact would it have upon the budget request for FY 1986.

B. Please state or estimate the total amount of state taxes paid, or to be paid, by the SGLI program during 1984, 1985 and 1986. Please indicate whether this is based on a calendar or fiscal year basis.

C. Would cost savings during FY 1986 be significant if a legislative exemption is enacted?

Answers 9A, 9B, & 9C.

This recommendation was not considered in formulating the fiscal year 1986 budget request because, even if legislation were enacted on this subject, it would not have any budgetary impact.

The SGLI program is administered by the Prudential Insurance Company. That company pays the state premium taxes and fees directly to each state. The Veterans Administration does receive premiums collected by the service departments. These premiums are passed through the SGLI Revolving Fund and sent to Prudential.

Elimination of state premium taxes would lower the expenses of the SGLI program. This would represent a benefit to service personnel in that reduced expenses could ultimately be reflected in the premium rate charged. However, elimination of these taxes would not produce any "cost savings," as such, to the government since SGLI is a self-supporting program.

The total state premium tax paid during fiscal year 1984 was $3.3 million. The estimates for fiscal year 1985 and 1986 are $2.7 million and $2.9 million respectively. The decline in fiscal year 1985 is due to a reduction in the SGLI premium rate which was effective on July 1, 1984.

Question 10. A. **Please provide the number of defaults (at least 90 days in arrears) for VA guaranteed home loans for each of the last twelve months. Please also state this data in terms of percentage of loans.**

B. **Please provide the number of VA loans which have been foreclosed for each of the last twelve months. Please also state this data in terms of percentage of loans.**

C. **How do these figures compare to the private sector?**

Answer 10. A. **The following table shows the number of GI home loan defaults pending at the end of each of the last 12 months and the percentage this number is of the outstanding GI home loans.**

	GI Home Loan Defaults Pending End of Month	% of Outstanding GI Home Loans
Feb 1984	94,579	2.28
Mar	96,315	2.32
Apr	95,621	2.30
May	94,443	2.27
Jun	92,863	2.23
Jul	91,713	2.20
Aug	91,079	2.19
Sep	90,829	2.18
Oct	93,451	2.25
Nov	96,058	2.31
Dec	97,139	2.34
Jan 1985	100,922	2.43

B. **The following table shows the number of GI home loans foreclosed during each of the last twelve months and the percentage this number is of the outstanding GI home loans.**

	GI Home Loans Foreclosed	% of Outstanding GI Home Loans
Feb 1984	1,578	0.038
Mar	1,813	0.044
Apr	1,821	0.044
May	2,059	0.049
Jun	1,824	0.044
Jul	1,587	0.038
Aug	1,986	0.048
Sep	1,755	0.042
Oct	2,015	0.048
Nov	2,140	0.051
Dec	1,917	0.046
Jan 1985	1,958	0.047

C. We do not have comparable data for conventional loans. Information provided to us by the Mortgage Bankers Association indicates that the default rate on VA guaranteed loans is lower than on FHA loans but higher than the conventional rate.

Question 11. What is the total number of homes in the VA portfolio and also the number of VA loans currently in foreclosure?

Answer 11. On January 31, 1985, there was a total of 21,585 properties in the VA inventory. Also on that date 58,429 notices of intent to foreclose were pending. It should be noted, however, not all of these loans are as yet in foreclosure and that many of the defaults will be cured, some even after foreclosure has begun.

Question 12. How do you account for the continuously high rate of foreclosures despite the steadily improving nation ecomony?

Answer 12. The primary reasons for the continued high rate of foreclosures are as follows:

- The economy has not recovered equally in all areas of the country.
- Many families who qualified for home loans based on their combined incomes have either lost or incurred a reduction in that income and are unable to meet their mortgage obligations.
- Stable or declining values preclude delinquent borrowers from readily selling their homes to avoid foreclosure.

• Previously unemployed borrowers return to jobs and can't cure their loan defaults because they have become overobligated while out of work or are now working at lower paying jobs.

• Marital problems lead to a high incidence of foreclosures.

• Some states have ended foreclosure moratoriums and the backlog is now being processed.

• Many properties securing delinquent loans have been released from bankruptcy proceedings and are now being foreclosed.

Question 13. The VA budget books indicate that the VA currently acquires about 90 percent of the properties foreclosed, and during 1986, the VA expects to acquire 80 percent of the foreclosed properties. Please explain how these percentages were determined.

Answer 13. In FY 1983 VA acquired properties in 93.0 percent of cases involving the foreclosure of guaranteed home loans. In FY 1984 this figure was 90.1 percent. The decrease in the percentage of property acquisitions can be attributed to changes the VA has made in determining the net value of properties securing foreclosed GI loans.

The Deficit Reduction Act in 1986 is expected to result in a further decline in the number of properties acquired.

Question 14. How long does the VA hold a house while it refurbishes and markets the property and how does this compare with other government lenders (such as HUD), state programs, and private lenders.

Answer 14. VA's average holding time was 10.9 months for properties sold during FY 1984. This compares with average holding times ranging from 2 months to 6.8 months in state programs surveyed which have modest inventories and offer very favorable seller-financing. Among the private lenders we surveyed, holding times range from 7 months to 11 months. Their property inventories are also modest in comparison with VA's. The holding time for FmHA properties is approximately 13 months while FHA indicates a holding time of only 5.6 months. Even though the FHA holding time is considerably less than VA's, we note that their average loss per property ($15,750) is approximately $5,100 greater than VA's ($10,611) and that their average sales price ($29,900) is approximately $11,000 less than VA's ($41,035).

Question 15. What marketing methods does the VA use to sell acquired homes?

Answer 15. VA relies principally on private sector real estate brokers to sell VA-owned properties. We use an open listing system, under which any participating broker may try to sell any listed property. Basic compensation for a selling broker is a 5 percent, unsplit sales commission. In addition, commission bonuses of up to $500 are payable on many hard-to-sell properties.

Generally, participating brokers receive current sales listings published by our field offices. Some offices publish their listings in local newspapers. To keep brokers informed of property availability status, our offices use telephone recording devices, and we are experimenting with computerized "bulletin boards" for property status information at several offices.

To supplement the brokered sales method, we have begun to use public sales auctions. Following a successful two-night auction of 200 homes in Detroit in October 1984, we are in the process of contracting for 1985 auctioneer services as well, to be used wherever we think this technique could be most beneficial to our sales program.

Question 16. How do VA marketing costs compare to costs in other agencies and private sector lenders?

Answer 16. VA's average marketing cost for properties sold in FY 1984 was 5.29 percent of the selling price, or an average of $2,040 per property sold. This cost includes our normal 5 percent sales commission, bonuses and advertising costs to promote the sale of the property. This compares with an average of $2,700 per property for properties which were sold by FHA whose sales commission rate is 6 percent in most cases and as high as 8 percent for their harder-to-sell properties. Although the rate of commission is higher for FHA properties, their average sales price of $29,900 is significantly less than VA's average $41,000 sales price. Sales commissions for FmHA-owned properties are determined by the rate prevailing in the states in which the properties are sold. Among private sector lenders, we found that the sales commission is generally 6 or 7 percent. However, advertising is generally done by someone other than the lender, i.e., the sales broker or the company responsible for servicing the former loan account.

Question 17. How has the VA changed its marketing strategy in response to the dramatic changes in the housing industry over the last decade?

Answer 17. In an era of high interest rates and declining real estate values in many areas where we have extensive property inventories, the key to our marketing has been a more aggressive pricing strategy. We are also offering discounts for cash, sales commission bonuses over and above the normal 5 percent, and will accept purchase offers below our stated list prices for many properties. We are also planning to make increased use of public auctions in order to move large numbers of properties in short periods of time.

Question 18. To minimize the number of vendee loans made by the VA, the Deficit Reduction Act of 1984 requires that the VA make at least 25 percent, but not more than 40 percent, of its sales of acquired properties for cash. Also, the Deficit Reduction Act requires that the VA take steps to maximize cash sales of acquired properties within this 25-40 percent limitation. Please indicate whether these statutory directives are being implemented and to what extent.

Answer 18. The statutory requirement that VA make at least 25 percent of its sales of acquired properties for cash was implemented in VA field stations effective October 1, 1984. Each VA regional office is expected to meet the 25 percent minimum and encouraged to do as close to 40 percent as possible. For the last three months of FY 1984 our cash sales averaged 8.91 percent of total property sales. However, during the first three months of FY 1985, this percentage was increased to 19.6. VA field stations were informed of the necessity to pursue cash sales aggressively in order to achieve the statutory requirements. Some of the tools which we have promoted in order to reach this goal are aggressive pricing of properties in order to reach the all-cash market value, 10 percent discounts for cash, sales listings offering properties for sale for cash only, an increase in the number of properties being repaired in order to make them eligible for conventional financing or for government-guaranteed or insured financing, payment of reasonable discount points, and auction sales. We expect to use auction sales as needed to help meet our cash sale requirement.

Question 19. In response to Senator Cranston's prehearing question #3, the VA estimated that it would collect $152,600,000 in guaranteed-loan funding fees in FY 1986 if the fee remained at one per cent and if the fee is raised to five per cent as proposed, the VA estimated that it would collect $759,200,000 in FY 1986. The VA based these projections on the assumption that there would be no change in the number of loan originations with an increase in the funding fee from one to five per cent.

A. What amount does the VA estimate it would collect in funding fees in FY 1986 if the fee is raised to:

- o 2 per cent
- o 3 per cent
- o 4 per cent

B. Please state the assumptions underlying the requested estimates.

Answer 19. A. The VA estimates it would collect funding fees in FY 1986 as follows:

Percent of Fee	Estimated Funding Fee Collections ($000)
2	$305,200
3	$457,800
4	$610,400

B. These estimates are based upon no change in the number of loan originations. In addition, we have assumed that the vendee loan fee would be the same as the GI fee.

Question 20. A. What would be the additional cost per month for an average VA guaranteed home loan if the loan origination fee was increased to:

- o 2 per cent
- o 3 per cent
- o 4 per cent
- o 5 per cent

B. Please describe the assumptions underlying the requested estimates.

Answer 20. A. The additional cost per month based upon the FY 1986 average VA guaranteed home loan is as follows:

Percent Fee	Additional Cost
2	$ 7.25
3	$ 14.50
4	$ 21.75
5	$ 29.00

B. These figures were based upon a 30-year loan with an interest rate of 12½ percent and an estimated average amount of $67,877.

Question 21. Could a lesser percentage increase in the origination fee keep the revolving fund solvent without creating a surplus during FY 1986? How can you determine accurately what fee level would be appropriate?

Answer 21. The five percent funding fee proposal is part of the Administration's policy to collect user fees from individuals receiving Federal credit. The revenue generated by the fee provides a reserve against future losses from foreclosure. The increase of the fee to 5 percent is not specifically targeted to the projected revolving fund deficit in FY 1986. Instead it is intended to eliminate the need for appropriations after FY 1985.

It is very difficult to predict exactly the level of funding fee necessary to negate the need for appropriations in FY 1986 because of the many variables involved. Assuming that loan originations in FY 1986 remain at the 220,000 figure, however, a fee in the range of 3.5 to 4 percent would be necessary.

Question 22. If the five per cent origination fee proposal is not adopted, what do you estimate would be the amount of funds the VA will need for the loan guaranty revolving fund to remain solvent over the next three years? Please state the assumptions underlying your response.

Answer 22. If the five per cent fee proposal is not adopted the VA will need appropriations to offset the shortfall of revenues in the Loan Guaranty Revolving Fund. The amount necessary for a three year period would vary greatly depending on the economic conditions. Our current estimates, based on an improving economy and a steady decline in foreclosures, indicate the need for $404.6 million in 1986, $307.9 million in 1987, and $369.4 million in 1988. If the rate of foreclosures continues at the high rate currently being experienced, the amount would be greater. If the foreclosure rate drops significantly and VA can continue or improve on the level of property sales, however, the appropriation requests would be lower than originally estimated.

Question 23. If the 5% origination fee proposal is not adopted, are there other alternatives which you can recommend to solve the financial problems the loan guaranty revolving fund is experiencing in terms of short and long-term policy and program goals? Please specifically elaborate on the efforts the VA has initiated to streamline the time between default and foreclosure on a VA guaranteed loan.

Answer 23. The financial difficulties of the Loan Guaranty Program stem in large part from changing economic conditions. During the past 4 years VA has experienced an extremely high number of foreclosures requiring costly expenditures from the Loan Guaranty Revolving Fund. In this connection VA's inventory of properties has grown to twice the level on hand in FY 1981. There are no easy solutions to these problems. If the 5% fee is not enacted, it will take a 3 to 5 year period of declining foreclosure rate and vigorous property sales to put the revolving fund in a more stable financial condition. Since 1978, the VA has relied heavily on transfers of unobligated balances from the Direct Loan Revolving Fund (an average of $200 million a year) to finance shortfalls in the Loan Guaranty Revolving Fund. These balances available for transfer have been substantially depleted.

When a guaranteed loan is reported to be in default, VA immediately attempts to contact the borrower by letter, mailgram, telephone, and/or a personal visit to the property. The purpose of this effort is to review the borrower's individual situation and determine what options are available based on the facts in the case. If the borrower has the ability to resume regular payments on the loan and repay the delinquency, VA works with the holder and the borrower to reinstate the account. If the default cannot be cured, the borrower is advised of the importance of taking other action to avoid foreclosure and to consider selling the property to recover any equity he or she may have.

Once it is determined that the borrower will be unable to repay the delinquency or sell the property, the holder is expected to take prompt action to terminate the loan. It is the sole responsibility of the holder of the loan to initiate and process foreclosure. The time it takes to terminate the loan will vary depending on state law. For example, in Texas it takes three to four weeks to complete foreclosure, whereas in Cuyahoga County, Ohio, it takes 12 months. If there is a bankruptcy situation, the holder is often precluded from taking an action to foreclose. Some states have redemption laws which slow up the foreclosure process. VA continues to monitor the status of the default to ensure that the loan is terminated in the most expeditious manner. When it is determined that there is an undue delay which will increase costs to the Government, VA notifies the holder and may establish a cutoff date beyond which no further interest or charges will be allowed in a claim under the guaranty.

Question 24. **During the hearing before the Senate Veterans' Affairs Committee on February 20, there was some uncertainty as to whether or not there may be a reduction in the utilization of the VA home loan guaranty program if the loan origination fee is increased to five per cent. The VA had previously indicated in its written response to Senator Cranston's prehearing question that the number of loans would not be affected by the increase of the funding fee to five per cent.**

A. **Please explain what, if any, impact the proposed five per cent loan origination fee will have upon the utilization of the VA home loan guaranty program by veterans. Please include:**

- **detailed data and statistics; and**
- **a complete description of the analyses and assumptions underlying your response.**

B. **If all government loans become subject to the five per cent user fee, please provide your views on whether the VA loan guaranty program would still provide additional benefits to veterans which would not be available through other home loan financing sources? Would the program still be attractive to veterans?**

Answer 24. A. **The VA's FY 1986 budget submission does not account for any reduction in loan activity because of the increased fee. Since the budget has been presented to Congress we have been in contact with real estate industry groups such as the Mortgage Bankers Association, the National Association of Realtors and the National Association of Home Builders, regarding this proposal. All these organizations predict a falloff in loan originations if the fee is increased. Although the estimates vary, they generally fall in the 20-50 percent range. We understand that the Congressional Budget Office recently reported to Congress an** estimate of a 20 percent reduction in GI loans in connection with this proposal.

B. The program will still be attractive because of its basic features, i.e., no money down, fully assumable loans and no prepayment penalty.

Question 25. What, if any, impact would the authorization of negotiated interest rates between borrowers and lenders have upon utilization of the VA home loan guaranty program?

Answer 25. Presently, many sellers are reluctant to sell with VA financing because of the prohibition against veteran-buyers from paying any of the discount points.

Under this proposal, the veteran-buyer, the seller, and the lender can negotiate as to what the interest rate will be and who will pay some or all of any discount points. Thus a veteran should have more homes to choose from and the transaction can be tailored to fit the needs and circumstances of the parties involved.

Question 26. What, if any, impact would the repeal of the transfer authority of surplus from the Direct Loan Revolving Fund to the Loan Guaranty Revolving Fund have upon outyear appropriation requests?

Answer 26. If the proposal to increase the funding fee to five percent is enacted there will be no need for further transfers from the Direct Loan Revolving Fund. If the proposal to increase the fee is not enacted, however, the inability to transfer from the Direct Loan Revolving Fund will increase appropriation requirements necessary to support the program in the out years.

Question 27. Please provide for the record a breakdown of the number of participants, by veteran and by active duty military status for all loan guarantees made during the past two fiscal years and a projection for FY 1986.

Answer 27.

Entitlement	1983 Actual	1984 Actual	1986 Estimate
World War II	9,573	9,071	7,700
Public Law 94-324	414	380	440
Korean Conflict	7,094	6,744	5,500
Post Korean	21,769	20,276	17,600
Vietnam Era	112,339	109,548	96,800
Post Vietnam Era	22,357	27,243	24,200
Servicepersons	43,292	50,592	44,220
Restored	24,908	26,519	23,100
Surviving spouses and wives of POW/MIA	485	629	440
Total GI loans closed	242,231	251,002	220,000
Direct loans sold with with a guaranty	2,891	586	0
Total guaranteed or insured loans	245,122	251,588	220,000

Question 28. Your November 13, 1984, letter to the former Chairman of the Senate Veterans' Affairs Committee, Senator Alan K. Simpson, transmitted certain program changes proposed in the 1983 Medical District Initiated Program Planning (MEDIPP) plans.

A. Please provide a list by program and resources (including dollars and FTEE) of the MEDIPP proposals which were not included in the fiscal year 1984 budget request.

Answer 28. A. The chart below lists the initial 1986 MEDIPP initiatives that were not included in the 1986 President's budget (dollars in thousands):

Initiative:	MEDIPP INITIATIVES B.A.	MEDIPP INITIATIVES FTEE
Outpatient workload...........	$ 77,312	1,546
Community nursing workload....	50,120	...
Adult day health care..........	10,696	150
Community residential care....	797	22
Mental hygiene clinics........	5,568	104

Initiative:	MEDIPP INITIATIVES B.A.	FTEE
Hospital based home care	$1,876	45
Satellite outpatient and rural outreach centers	12,242	204
Day treatment centers	5,908	116
Day hospital	4,037	79
Geriatric evaluation units	6,482	206
Cardiac surgery	5,140	110
Renal transplant	2,170	36
VA domiciliary staffing incr.	8,915	217
Ambulatory surgery	2,002	29
Magnetic resonance imaging	12,132	30
Nuclear teletransmission network	702	5
In-house Invivo	418	4
Digitalized vascular imaging	900	...
Post traumatic stress disorder centers	10,593	235
Cardiac catherization labs	4,994	16
Unit dose	14,349	439
VA/DOD contingency staffing	694	29
Total	$240,647	3,621

Question 28. B. What, if any, guidelines or limitations, such as dollar constraints or ceilings, are used or are being considered for use by medical districts to assist in ranking their priorities and linking the MEDIPP and the budget processes?

Answer 28. B. During the 1983 MEDIPP cycle, planning guidelines required VA medical districts to prioritize the MEDIPP goals and objectives based on preceived needs exclusive of external constraints. The relative importance assigned by the medical districts to the goals and objectives facilitated identification of priority areas in the development of the Department's budget request.

During the 1984 planning cycle, the guidelines provided to the medical districts shifted the focus of prioritization away from goals and objectives to specific action items. Actions are the means through which planned goals and objectives are translated into implementation strategies. The medical districts were given the latitude to select from several methodologies the best means to perform the prioritization task. The priorities assigned were then considered to be a reflection of the relative importance of the actions to the districts.

Consideration is being given to adopting a similar approach for the 1985 MEDIPP cycle. In addition to prioritizing MEDIPP initiatives, the medical districts will be requested to determine, within several budgetary scenarios, which of the approved MEDIPP actions could be implemented in the next several years.

Question 29.

How does the VA balance the resource requirements of the top priorities determined by the MEDIPP process and those derived from the Five-Year Medical Facility Construction Needs Assessment?

A. **If several top-ranked MEDIPP initiatives require no funding, are resources allocated to support these initiatives while a proportionate share of construction funding is reduced?**

B. **Or, do the MEDIPP and construction needs assessments and budgets operate on two independent tracks with separate budget ceilings?**

C. **What would be the advantages and disadvantages of linking the medical care and construction budget requests?**

Answers 29A, 29B, and 29C.

The MEDIPP process is the department's primary planning effort. All approved MEDIPP construction initiatives become a part of the 5-Year Medical Facilities Construction Plan.

Approved construction projects are included in the Major and Minor Construction Appropriation request. This provides for the constructing, altering, extending or improving of any VA facility including planning, architectural and engineering services and site acquisition.

All operational MEDIPP initiatives (as opposed to construction initiatives) are included in the Medical Care Appropriation request. Operational requirements include staffing, equipment and support to activate newly constructed DM&S projects which have been undertaken with previously appropriated funding in the major and minor construction programs and the DM&S maintenance and repair program.

Although both Construction and Medical Care initiatives have their basis in MEDIPP and over time are interrelated, their budgeting is basically separate. This division fiscally accommodates the nonrecurring funding associated with construction versus the recurring (or annual) funding necessary to operate.

The advantage of combining both budgets would be the ability to highlight the total cost (both construction and initial operation) of any given project.

However, the disadvantages outweigh the advantage. First, for any given project, the budgeting for operational

resources usually lags one to three years behind construction budgeting. In any given budget year, resources would probably not be required for both construction and operations. Secondly, the seclusion of activation initiatives from other operational requirements would skew the total operational budget. For the budget year workload, staffing ratio and per diem estimates would be incomplete (i.e., minus the activation impact). The current year and actual years, however, would include activation as part of the recurring hospital requirements. This would make for confusing budget reviews.

The Agency makes every attempt to present a balanced budget request within the confines of the budget appropriation structure.

Question 30A. According to the data on pages 5-37 and 5-38 of the budget documents, the VA expects to operate 1,286 less hospital beds and 1,611 more nursing home beds at the end of fiscal year 1986, compared to 1984.

What percentage of the reduction of hospital beds will be attributable to the closing of hospital programs, such as surgery units?

Answer 30A. Of the reduction of 1,286 VA hospital beds, 62 beds (4.8%) will result from closing bed sections: 34 surgery beds at VAMC Livermore and 28 rehabilitation medicine beds at VAMC St. Louis.

Question 30B. What percentage of the increase in nursing home beds will be the result of conversion of individual hospital beds?

Answer 30B. Of the increase of 1,611 VA nursing home beds, approximately 204 beds (12.7%) will result from the conversion of hospital beds.

Question 30C. On page 5-16 of the budget document, it states that approximately 440 hospital beds will be converted to intermediate hospital care and nursing home care beds and 204 beds will be converted to nursing home care. Will a total of 644 hospital beds be converted?

Answer 30C. A total of 443 VA hospital beds in medical, surgical, and psychiatric bed sections are to be converted: 239 to intermediate hospital beds and 204 to nursing home beds.

Question 30D. What criteria was used to determine whether to convert hospital beds into nursing home care beds? What is the total potential for conversion throughout the VA system?

Answer 30D. Considerations that lead to a decision to convert hospital beds into nursing home care beds include (1) a projected increase in the need for nursing home beds at a medical center, (2) a projected decrease in its need for hospital beds, and (3) physical facilities for which conversion from the one use to the other is determined to be both (i) architecturally feasible and (ii) less costly than new construction. The total potential for conversion throughout the VA system has not been assessed.

Question 30E. Did the 1983 MEDIPP plans include this recommendation? If not, how and when was the proposal developed?

Answer 30E. The hospital/nursing home bed conversion proposal had its origins in the 1983 MEDIPP plans, but in its current form it differs from what was proposed in MEDIPP. It originated from six 1983 MEDIPP initiatives which involved approximately 160 specific MEDIPP actions at a large number of VA medical centers. As submitted in the 1983 MEDIPP plans, these actions did call for a net reduction in beds.

Question 31. According to data on page 5-37 of the budget documents, the VA plans to increase the number of intermediate beds in VA hospitals while reducing all other beds. On page 5-3, you state that intermediate beds provide a level of care between acute and long-term or extended care.

A. What is the difference between an intermediate bed, an acute hospital bed and a nursing home bed in terms of the patients, served, level of staffing provided, and per diem costs?

Answer 31A. The VA/GAO bed sizing model in projecting the future need for medical beds in both acute and intermediate levels automatically allocates, on the basis of past experience, non-acute medical days of care to the intermediate bed section. This automatic allocation results in the planned increase in the number of intermediate beds. Acute hospital beds are allocated on the basis of community lengths of stay.

A VA Central Office Intermediate Care Task Force has been engaged in a definitive study of the issues surrounding acute and intermediate care bed sections and has made a series of recommendations to the Chief Medical Director. These recommendations, including such things as the re-designation of certain acute and intermediate care beds based on the level of care currently provided in those beds, have been approved in principle.

The task force is currently developing appropriate modifications of the bed-sizing model to project future bed needs. After an appropriate analysis of these data, program guidance based on this information will be published as part of the Medical District Initiated Program Planning (MEDIPP) process, and a phased re-designation of beds and levels of care will take place. The accomplishment of this task will eliminate criticisms directed at utilization of hospital beds in the VA system.

The demand for intermediate and nursing home beds remains high and will grow as the veteran population ages. Occupancy in the intermediate care bed section nationwide is 87.1% and 93.4% in VA nursing home care beds nationwide. The nursing home care program maintains an active waiting list. In FY 1984, 2,267 patients were on nursing home care waiting lists. It should be emphasized that eligibility for care in these bed sections differs substantially. The eligibility for transfer to the intermediate care bed section is governed by the same regulations dealing with hospital care. Admission to a nursing home care program is substantially different and favors the service-connected patient. For example, nonservice connected patients can only be admitted to a VA nursing home care unit from a VA hospital bed.

The level of care provided in acute hospital beds and the intermediate care bed section is somewhat more intensive and costly as measured by such indices as nursing care hours per day per patient and per diem costs. A recently completed survey of long-term care patients, done as a part of the resource allocation system for long-term care, confirmed these findings demonstrating in addition that the care provided in the intermediate care bed section is significantly different and requires greater resources than patients in nursing homes.

Question 31B. Is there a growing need in the VA system for this unique level of care?

Answer 31B. The need for intermediate care in the VA system is subject to several interpretations. The Intermediate Care Task Force recommendations proposed the re-designation of many patients currently occupying intermediate care beds as nursing home patients. Since in most cases their requirements for care are measurably greater, the soon to be implemented resource allocation system for long term care must incorporate a mechanism for measuring these requirements and allocating resources to the nursing home care program in a way which will accommodate these needs. It is anticipated that the current system can in fact accommodate this change and will enable the Department of Medicine and Surgery to develop an extended hospital care bed section, significantly smaller than intermediate care and much more clearly focused on the problems associated with rehabilitation, convalesence, and outplacement to less intensive, less restrictive, non-hospital, institutional and non-institutional levels of care. The development of such a program will aid in the development of a vertically integrated and programmatically balanced comprehensive system of care.

Question 31C. What longer-range plans, if any, do you have to convert unneeded or underused acute care beds to intermediate care?

Answer 31C. The re-designation and appropriate utilization of acute and intermediate care beds and the development of an extended hospital care section do not, as a specific action, contemplate the conversion of acute care beds to intermediate care though the net effect will accomplish the same overlapping goals; namely, the proper utilization of hospital beds.

Question 31D. What savings, in terms of staffing and per diem costs, will be realized from such conversions?

Answer 31D. The savings realized in this plan are difficult to estimate at this time. The proper utilization of hospital beds will result in some savings. It is anticipated that there will be a net reduction of hospital beds overall; this too represents a potential saving. The need for additional resources in an expanded nursing home care program treating a higher proportion of severely disabled and totally dependent patients will necessarily involve increased cost. In addition the development of a more focused and clinically effective program of rehabilitation, convalescence, and outplacement in the proposed extended hospital care section will also require resources. Yet to be addressed, but an integral part of the Intermediate Care Task Force plan, are issues surrounding long term psychiatric care. Final estimates of bed section size, staff composition, and cost have yet to be determined; and target dates for the implementation of the proposed plan have yet to be established. It is reasonable to assume that the task force will complete its work within three months and that appropriate MEDIPP guidance will be available shortly thereafter.

Question 31(a). By the end of fiscal year 1986, you project that VA hospitals will have 15,628 surgical beds which is 541 less than they had at the end of fiscal year 1984, and 1,497 less than at the end of fiscal year 1981.

A. How much of the reduction from 1984 to 1986 will be the result of the closing of entire surgical programs at VA hospitals? How much will be due to reductions in continuing programs?

Answer 31(a)A. Of the decrease of 541 surgery beds during fiscal years 1985 and 1986, 34 beds will result from closing the surgery bed section at VAMC Livermore. The remainder will result from bed decreases at VAMCs where surgery bed sections will continue to operate.

Question 31(a)B. What criteria are used to decide to close surgical programs?

Answer 31(a)B. The VA Bed Sizing Model projects future surgical bed requirements based upon the application of current, age-specific surgical utilization rates, lengths of stay, and veteran population estimates. The resultant bed projections then are used in concert with various other considerations to assess program necessity, including the minimum operating levels needed to maintain service viability, the cost effectiveness of a closure, the implications on existing or planned medical school affiliations, the availability and accessibility of like services at other VA facilities, the magnitude and complexity of surgical case-mix, and the presence and capability of ambulatory surgical services. If a surgical program were to be closed, it would be because workload is insufficient to justify retention based on clinical and economic concerns.

Question 31(a)C. What, if any, impact does this have on veterans requiring surgical procedures?

Answer 31(a)C. Eligible veterans entitled to the receipt of VA surgical care are provided such services through the existing facility on an ambulatory basis, where appropriate; through other VA facilities that are available and accessible; or provided through contractual/fee-basis arrangements in the absence of VA capability.

Question 31(a)D. How many cardiac surgery programs and heart transplant programs are included in the fiscal year 1986 budget?

Answer 31(a)D. There are a total of 50 cardiac surgery programs (44 of which are in-house programs and 6 contracts). We have only one heart transplant program.

Question 31(a)E. Please provide a list by facility and resources (dollars and FTEE) to be allocated to each of these programs for fiscal year 1986.

Answer 31(a)E. The allowances provided for the cardiac surgery program in 1985 and 1986 depend on several factors. One major factor is the level of funding received by the medical centers in each fiscal year. The funding level for this program is not separately identified as a line item in the budget request. The level of actual funding for this program will be determined by each facility director based on the allowances received during budget implementation.

Question 32. Please explain the difference in the FY 1986 request f medical care employees (FTEE) from the FY 1985 appropriated levels?

A. Did you, in fact, fully staff at the FY 1985 appropriated levels?

B. Does the 1986 apparent increase reflect an increase from actual staffing levels?

C. If not, please explain why not and for which programs and services the funding levels for FY 1985 were used?

Answer 32A. The appropriated ceiling increase of 3,367 FTEE in 1985 (2,747 FTEE increase included in the 1985 budget plus the 620 FTEE Congressional add-on) was allocated to the VAMC's. However, the VAMCs are not maintaining the base level of FTEE. This reduction is due to the proposed rescission (in accordance with the Deficit Reduction Act), an adjustment in the common service field support by the Department of Veterans Benefits and an absorption of unfunded supplemental pay requirements resulting from the governmentwide policy requiring agencies to absorb a minimum of 50 percent.

A high priority has been placed on achieving the 1985 budgeted workload levels. The first quarter FTEE level was 190,482. Within this level we are exceeding our planned workload levels. The 1985 current FTEE estimate of 191,849 will enable the Agency to provide the budgeted level of services, both patients treated and outpatient visits and enable the Agency to bridge to the 1986 employment level of 192,048.

Answer 32B. The 1986 level of employment (192,048) reflects an increase of 199 FTEE over the level of FTEE necessary to operate the system in 1985 (191,849).

Answer 32C. The 1985 current average employment (FTEE) estimate of 191,849 is 2,092 below the level appropriated by Congress (193,941 included in the 1985 budget, as adjusted for the Congressional add-on). The 2,092 FTEE reduction from the appropriated FTEE level is the result of three things. First, funding for 133 FTEE is proposed for rescission in accordance with the Deficit Reduction Act. Second, a 9 FTEE reduction in jurisdictional employment reflects a transfer from jurisdictional FTEE to common service FTEE and more accurately reflects field support provided by the Department of Veterans Benefits. The third reduction of 1,950 FTEE reflects the impact of absorbing unfunded supplemental pay requirements totaling $106,695,000. No resources are being realigned to support specific programs or services in lieu of FTEE.

Question 33. What are the most pressing recruitment and retention difficulties with respect to VA health care personnel?

Please provide a breakdown by occupational group, number of vacancies, and turnover rate of the 5 VA health care occupational groups experiencing the most severe recruitment and retention difficulties.

Answer 33. Based on 1984 data, these are the occupations facing the most pressing recruitment and retention problems in DM&S:

OCCUPATION	TOTAL EMPLOYED	VACANT	TURNOVER RATE
Physician	11,900 (approx.)	611	Varies with Specialty
Licensed Practical Nurse	9,200 (approx.)	311	20.3%
Pharmacist	2,700 (approx.)	122	14.8%
Physical Therapist	630	90	14.3%
Occupational Therapist	660	37	17.2%

Under P.L. 98-160, LPN's and Physical Therapists are being converted to Title 38 for certain personnel functions. This change is expected to alleviate some of the recruitment and turnover problems for these two groups. Pharmacist recruitment is hampered by severe upward salary pressures in the private sector and a short supply in many locations. This problem is expected to continue through the foreseeable future. Occupational Therapists can be recruited at the entry levels, but the turnover rate indicates we are losing them after they gain experience and improve their marketability.

For physicians, VA's most comparable employment setting is the medical school. There is evidence of significant recruitment and retention problems in VA vis-a-vis the medical school setting. VA's overall physician turnover rate of 10.2% far exceeds the medical school rate of 3.8%. VA turnover rates for individual specialties range from 5.6% to 12%.

Question 34. What, if any, impact would the proposed 5% pay reduction, the 1% per year productivity increase, and the GS 11-15 grade reduction plan have on the VA's ability to be competitive with private sector health care systems with respect to the recruitment and retention of health care personnel?

What specific management initiatives have been or will be initiated to implement the 1% productivity increase?

Answer 34. Recruitment in many health care occupations, especially physicians, registered nurses, licensed practical nurses, physical therapists, pharmacists, and various highly specialized technicians, is salary sensitive. An across-the-board salary reduction may affect recruitment and retention in varying degrees and in various geographic areas. However, with prospective reimbursement systems, the private sector is changing its employment patterns. These changes may offset any recruitment and retention problems resulting from payroll changes you've identified.

The medical care appropriation has experienced increased productivity over the past several years. For instance, the 1985 budget estimated a patients treated level of 1,279,000 in 1984. The 1984 actual patients treated level of 1,290,000 was achieved with a slightly lower average employment level. It is difficult to determine the extent increased productivity can be achieved in any year. In recent years, productivity increases have allowed the Department to absorb unfunded requirement (supplemental and pay requirements, higher than anticipated inflation rate, and the impact of unfunded legislation increasing eligibility requirements) without any appreciable impact on workload levels. Past budget submissions (current year and budget year workload estimates) were prepared based upon productivity achievement in the actual year. The 1986 budget workload and employment estimates anticipate an additional one percent increase in productivity to occur in 1986.

Increases in productivity can be achieved in several ways. The primary way this has been done is through improved medical treatment practices. These practices have reduced the length of patient's stay. In the last 10 years, the average hospital stay has been reduced from 31 days in 1974 to just over 20 days in 1984. The 1986 budget assumes this downward trend in length of stay will continue and allow the Department to meet the budgeted workload levels. Additionally, DM&S in line with the Administration's emphasis on productivity and efficiency, has scheduled a number of Most Efficient Organization (MEO) reviews, which should also identify areas to improve our delivery of services.

Question 35. Concerns have been raised that VA health care personnel who are currently providing direct patient care services, as compared to administrative personnel, would absorb a disproportionate share of the reductions required by the GS 11-15 grade reduction plan. Please address this concern and describe your implementation plan, including a breakdown, by medical facility and by Central Office, of the numbers and occupations of the proposed reductions.

Answer 35. Of the 15,871 Title 5 employees at grades 11-15 (14.6% of total FTEE), 68% are involved in direct patient care. It will be difficult to reduce the average grade of these positions as they typically represent the full performance level for the health care professional. Many of our health care professionals function in an independent situation, either by virtue of geography (over 172 medical centers and 226 outpatient clinics) or shift work, are in an "in-charge" situation, and are frequently the only practitioner of their respective discipline in a given area. The Department's difficulties in reducing grade 11-15 positions have been compounded by the additional staff required to implement unit dose drug programs and establish 52 new Veterans Readjustment Counseling Centers. In addition, the Office of Personnel Management (OPM) implemented a new qualification standard for Medical Technologists which redescribed a number of Medical Technologist positions into the grade 11-15 range. Since the Department's baseline date of March 31, 1984, the number of grade 11-15 Pharmacists, Social Workers and Medical Technicians has increased by 344 positions. To meet our reduction goal, these increases will have to be absorbed by other grade 11-15 occupations.

As of December 31, 1984, the Department must reduce 544 positions before September 30, 1985, to achieve its FY 1985 grade 11-15 ceiling of 15,327. A single reduction goal was assigned to each Region, Central Office and Veterans Canteen Service. Targets were based upon the mathematical application of a 2% reduction in the number of grade 11-15 positions as of March 31, 1984, plus projected additions for FY 1985. Regional Directors have primary responsibility for ensuring grade 11-15 position ceilings are met and have the authority to assign reductions to individual facilities. Attachment A shows the grade 11-15 on-board count as of December 31, 1984, and the position ceiling that must be achieved by September 30, 1985, for Central Office, Canteen Service, and for each Region, Medical District and facility.

The Department is expected to achieve these goals through normal personnel turnover. Reorganizations involving reductions-in-force and downgrading of encumbered positions with the express purpose of achieving established reduction goals have been prohibited. The six Regional Directors have indicated that for facilities to meet their grade 11-15 targets, a freeze will have to be imposed on both recruitment and promotion to all Title 5 grade 11-15 positions. Because reductions will be made as vacancies occur, there is no way to project the number of reductions that will be made in each occupation.

ATTACHMENT A

STATION	TYPE	STATION NO	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION I					
MEDICAL DISTRICT 1			783	758	25
BEDFORD MASS	[illegible]	[illegible]	111	109	2
BOSTON MASS	[illegible]	[illegible]	146	141	5
BOSTON MASS	[illegible]	[illegible]	71	68	3
	[illegible]	[illegible]	147	145	2
MANCHESTER N H	[illegible]	[illegible]	45	44	1
NORTHAMPTON MASS	[illegible]	[illegible]	76	76	0
[illegible]	[illegible]	[illegible]	70	69	1
[illegible]	[illegible]	[illegible]	78	73	5
WHITE RIVER JCT VT	[illegible]	[illegible]	39	33	6
MEDICAL DISTRICT 2			470	469	1
ALBANY N Y	[illegible]	[illegible]	108	111	+3
BATAVIA N Y	[illegible]	[illegible]	36	38	+2
BATH N Y	[illegible]	[illegible]	33	34	+1
BUFFALO N Y	[illegible]	[illegible]	133	126	7
CANANDAIGUA N Y	[illegible]	[illegible]	85	86	+1
SYRACUSE N Y	[illegible]	[illegible]	75	74	1
MEDICAL DISTRICT 3			1189	1142	47
BRONX N Y	[illegible]	[illegible]	147	150	+3
BROOKLYN N Y [illegible]	[illegible]	[illegible]	216	205	11
CASTLE POINT N Y	[illegible]	[illegible]	44	43	1
MONTROSE N Y	[illegible]	[illegible]	119	111	8
NEWINGTON CONN	[illegible]	[illegible]	51	50	1
NEW YORK N Y	[illegible]	[illegible]	193	189	4
NORTHPORT N Y	[illegible]	[illegible]	172	155	17
[illegible]	[illegible]	[illegible]	109	106	3
WEST HAVEN CONN	[illegible]	[illegible]	138	133	5
NEW YORK N Y	VAROC	[illegible]			
NON MEDICAL DISTRICT [illegible]					
[illegible]	VAROC	[illegible]			
[illegible]	[illegible]	[illegible]			
[illegible]	VARO	[illegible]			
WASHINGTON D C	VAROC	[illegible]			
TOTAL			2442	2369	73

ATTACHMENT A

STATION	TYPE	STATION NO	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION III					
MEDICAL DISTRICT 9			456	453	3
AUGUSTA GA (D)	GEN NP	[illegible]	144	144	0
CHARLESTON S C	GEN	534	52	51	1
COLUMBIA S C	GEN	544	74	81	+7
DECATUR GA	GEN	[illegible]	131	125	6
DUBLIN GA	GEN DOM	557	55	52	3
MEDICAL DISTRICT 10			518	492	26
BILOXI MISS (D)	[illegible]	[illegible]	100	101	+1
BIRMINGHAM ALA	GEN	521	109	102	7
JACKSON MISS	GEN	[illegible]	97	89	8
MONTGOMERY ALA	GEN	619	31	30	1
TUSCALOOSA ALA	PSY	679	91	88	3
TUSKEGEE ALA	GEN	[illegible]	90	82	8
MEDICAL DISTRICT 11			543	525	18
LEXINGTON KY (D)	GEN	[illegible]	128	123	5
LOUISVILLE KY	GEN	[illegible]	72	68	4
MEMPHIS TN	GEN	614	157	146	11
MURFREESBORO TN	PSY	[illegible]	88	94	+6
NASHVILLE TN	GEN	[illegible]	98	94	4
MEDICAL DISTRICT 12			661	657	4
BAY PINES FLA	GEN DOM	516	173	164	9
GAINESVILLE FLA	GEN	573	117	123	+6
LAKE CITY FLA	GEN	[illegible]	29	30	+1
MIAMI FLA	GEN	546	188	190	+2
TAMPA FLA	GEN	673	154	150	4
MEDICAL DISTRICT 13			515	478	37
ALEXANDRIA LA	GEN	[illegible]	45	46	+1
FAYETTEVILLE ARK	GEN	[illegible]	32	34	+2
LITTLE ROCK ARK (D)	GEN	[illegible]	220	199	21
NEW ORLEANS LA	GEN	629	144	131	13
SHREVEPORT LA	GEN	667	74	68	6
TOTAL			2693	2605	88

ATTACHMENT A

STATION	TYPE	STATION NO	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION II					
MEDICAL DISTRICT 4			736	706	30
COATESVILLE PA	PSY	542	115	108	7
EAST ORANGE N J	GEN	561	179	175	4
LEBANON PA	GEN	[illegible]	70	67	3
LYONS N J	PSY	[illegible]	109	102	7
PHILADELPHIA PA	GEN	[illegible]	137	133	4
WILKES-BARRE PA	GEN	[illegible]	80	77	3
WILMINGTON DEL	GEN	[illegible]	46	44	2
MEDICAL DISTRICT 5			312	287	25
ALTOONA PA	GEN	[illegible]	26	24	2
BUTLER, PA	GEN	[illegible]	38	37	1
CLARKSBURG, W VA	GEN	540	30	30	0
ERIE PA	GEN	562	28	26	2
PITTSBURGH PA (HD)	PSY	[illegible]	106	98	8
PITTSBURGH PA (U Div.)	GEN	[illegible]	84	72	12
MEDICAL DISTRICT 6			486	456	30
BALTIMORE MD	GEN	512	84	76	8
FT HOWARD MD	GEN	[illegible]	43	37	6
MARTINSBURG, W VA	GEN DOM	613	77	74	3
PERRY POINT MD	PSY	[illegible]	91	92	+1
WASHINGTON, D C	GEN	[illegible]	191	177	14
MEDICAL DISTRICT 7			456	423	33
BECKLEY W VA	GEN	517	24	22	2
HAMPTON VA	GEN DOM	[illegible]	99	93	6
HUNTINGTON, W VA	GEN	581	35	32	3
RICHMOND VA	GEN	[illegible]	186	169	17
SALEM VA	GEN	[illegible]	112	107	5
MEDICAL DISTRICT 8			382	363	19
ASHEVILLE, N C	GEN	637	70	66	4
DURHAM N C	GEN	[illegible]	96	92	4
FAYETTEVILLE, N C	GEN	[illegible]	39	37	2
MOUNTAIN HOME TN	GEN DOM	621	87	79	8
SALISBURY, N C	PSY	[illegible]	90	89	1
TOTAL			2372	2235	137

ATTACHMENT A

STATION	TYPE	STATION NO	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION IV					
MEDICAL DISTRICT 13			572	557	15
CHILLICOTHE OH	PSY	[illegible]	90	83	7
CINCINNATI OH	GEN	[illegible]	95	91	4
CLEVELAND OH (2 DIV)	GEN	[illegible]	259	255	4
COLUMBUS OH	OPC	[illegible]	22	22	0
DAYTON OH	GEN DOM	[illegible]	106	106	0
MEDICAL DISTRICT 14			382	366	16
ALLEN PARK MICH	GEN	[illegible]	128	128	0
ANN ARBOR MICH	GEN	[illegible]	108	103	5
BATTLE CREEK MICH	PSY	[illegible]	118	110	8
SAGINAW MICH	GEN	[illegible]	28	25	3
MEDICAL DISTRICT 15			329	312	17
DANVILLE ILL	GEN	[illegible]	99	93	6
FT WAYNE IND	GEN	[illegible]	26	27	+1
INDIANAPOLIS IND (2 DIV)	GEN	[illegible]	117	111	6
MARION IND	PSY	610	87	81	6
MEDICAL DISTRICT 16			363	342	21
IRON MOUNTAIN MI	GEN	[illegible]	23	22	1
MADISON WISC	GEN	607	81	74	7
TOMAH WISC	PSY	[illegible]	61	62	+1
WOOD WISC	GEN	[illegible]	198	184	14
MEDICAL DISTRICT 17			639	634	5
CHICAGO ILL (LS)	GEN	[illegible]	83	81	2
CHICAGO ILL (WS)	GEN	[illegible]	139	144	+5
HINES ILL	GEN	[illegible]	260	252	8
NORTH CHICAGO ILL	GEN	[illegible]	157	157	
MEDICAL DISTRICT 21			374	348	26
COLUMBIA MO	GEN	[illegible]	77	64	13
MARION ILL	GEN	[illegible]	31	38	+7
POPLAR BLUFF MO	GEN	[illegible]	23	21	2
ST LOUIS MO (2 DIV)	GEN	[illegible]	243	225	18
TOTAL			2659	2559	100

DM&S REGIONAL DATA SHEET (7 COLUMNS)

ATTACHMENT A

STATION	TYPE	STATION NO	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION V					
MEDICAL DISTRICT 19			368	346	22
FARGO N D	GEN	437	39	38	1
MINNEAPOLIS MINN	GEN	618	207	192	15
ST CLOUD MINN	PSY	656	76	73	3
SIOUX FALLS S D	GEN	438	46	43	3
MEDICAL DISTRICT 20			967	948	19
BONHAM TEX	GEN DOM	[illegible]	21	19	2
DALLAS TEX	GEN	549	140	140	0
HOUSTON TEX	GEN	580	211	204	7
KERRVILLE TEX	GEN	[illegible]	31	31	0
MARLIN TEX	GEN	611	21	18	3
MUSKOGEE OKLA	GEN	623	52	50	2
OKLAHOMA CITY OKLA	GEN	635	117	118	+1
SAN ANTONIO TEX	GEN	671	153	152	1
TEMPLE TEX	GEN DOM	674	107	105	2
WACO TEX	PSY	[illegible]	114	111	3
MEDICAL DISTRICT 21			329	316	13
KANSAS CITY MO	GEN	589	104	103	1
LEAVENWORTH KA	GEN DOM	686	82	80	2
TOPEKA KA	GEN	677	94	90	4
WICHITA KA	GEN	452	49	43	6
MEDICAL DISTRICT 22			419	418	1
DES MOINES IOWA	GEN	555	62	59	3
FT MEADE S D	GEN	568	40	41	+1
GRAND ISLAND NE	GEN	574	16	17	+1
HOT SPRINGS SD	GEN DOM	[illegible]	37	39	+2
IOWA CITY IOWA	GEN	584	69	68	1
KNOXVILLE IOWA	PSY	592	68	70	+2
LINCOLN NE	GEN	597	36	35	1
OMAHA NE	GEN	636	91	89	2
MEDICAL DISTRICT 23			356	349	7
CHEYENNE, WYO	GEN	442	14	14	0
DENVER COLO	GEN	554	95	93	2
FT HARRISON MONT	GEN	436	20	20	0
FT LYON COLO	PSY	567	47	49	+2
GRAND JUNCTION COLO	GEN	575	20	16	4
MILES CITY, MONT	GEN	617	13	13	0
SALT LAKE CITY UTAH	GEN	660	115	109	6
SHERIDAN WYO	PSY	666	32	35	+3
TOTAL			2439	2377	62

ATTACHMENT A

STATION	TYPE	STATION NO.	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION VI					
MEDICAL DISTRICT [illegible]			417	399	18
ALBUQUERQUE N M	GEN	[illegible]	103	95	8
AMARILLO TEX	GEN	[illegible]	37	37	0
BIG SPRING TEX	GEN	519	33	30	3
EL PASO TEX	OPC	[illegible]	20	17	3
PHOENIX ARIZ	GEN	[illegible]	98	89	9
PRESCOTT ARIZ	GEN DOM	[illegible]	39	37	2
TUCSON ARIZ	GEN	678	87	94	+7
MEDICAL DISTRICT [illegible]			1137	1109	28
LAS VEGAS NEV	OPC	[illegible]	18	18	0
LOMA LINDA CA	GEN	[illegible]	119	115	4
LONG BEACH CA	GEN	[illegible]	268	256	12
LOS ANGELES CA	OPC	[illegible]	53	50	3
SAN DIEGO, CA	GEN	[illegible]	144	137	7
SEPULVEDA CA	GEN	[illegible]	190	186	4
WEST LOS ANGELES CA (2 DIV)	GEN	[illegible]	345	347	+2
MEDICAL DISTRICT [illegible]			666	671	+5
FRESNO CA	GEN	[illegible]	53	54	+1
HONOLULU HAWAII	VARO	[illegible]	19	20	+1
LIVERMORE CA	GEN	[illegible]	36	32	4
MANILA P I	VARO	[illegible]	2	2	0
MARTINEZ CA	GEN	612	105	100	5
PALO ALTO CA (2 DIV)	PSY GEN	[illegible]	227	227	0
RENO NEV	GEN	[illegible]	57	56	1
SAN FRANCISCO, CA	GEN	[illegible]	167	180	+13
MEDICAL DISTRICT [illegible]			534	499	35
AMERICAN LAKE WASH	PSY	[illegible]	65	56	9
ANCHORAGE ALASKA	VARO	[illegible]	12	8	4
BOISE, IDAHO	GEN	531	50	46	4
PORTLAND OR (2 DIV)	GEN	[illegible]	153	138	15
ROSEBURG OR	GEN	[illegible]	43	38	5
SEATTLE WASH	GEN	[illegible]	127	132	+5
SPOKANE WASH	GEN	[illegible]	31	32	+1
WALLA WALLA WASH	GEN	[illegible]	21	21	0
WHITE CITY OR	DOM	[illegible]	32	28	4
TOTAL			2754	2678	76

Question 36. Were VA registered nurses excluded from the 3.5% cost of living increase effective January 1, 1985, for Federal employees?

A. If so, what was the rationale for this exclusion?
B. Were the VA registered nurses the only VA employees to be denied the cost of living increase?
C. If so, why?
D. Will Title 38 employees be subject to the proposed 5% pay reduction?
E. What impact would these salary reductions have on the VA's ability to recruit and retain qualified registered nurses?

Answer 36. Only those registered nurses being paid above-minimum entrance rates or covered by special salary rate ranges, under authority of 38 USC 4107(g), were excluded from the 3.5% comparability increase effective in January 1985. DM&S-wide, approximately 8,000 nurses are affected.

A. 38 USC 4107(g) authorizes VA to pay higher salaries when necessary for recruitment and retention in geographic areas where private sector pay levels make basic Federal statutory pay levels non-competitive. By law, these higher VA rates may be competitive with, but may not exceed, local community rates. DM&S has nearly 100 special higher salary authorizations in effect. During 1983 and 1984 the severe national nurse shortage has abated and private sector salary increases have moderated. Therefore, VA had an obligation to survey local private sector nurse salaries before passing on any pay increases to nurses on special rates. That survey has been completed and data are being analyzed in VACO. The 3.5% increase will be paid in those geographic areas where supported by the survey. The review will be completed by mid-April, 1985.

B. General schedule employees receiving special salary rates or above-mimimum entrance rates under 38 USC 4107(g) were also denied the 3.5% increase. Salary surveys have also been compelted for these employees and increases are being approved where justified.

C. Not applicable.

D. Yes.

E. Nurse recruitment is extremely salary sensitive. VA has made good use of the 38 USC 4107(g) salary authority to make sure nurse salaries are competitive. The survey discussed in (a) above represents a fine-tuning of the salary setting process and will be an annual occurrence from this year on. An across-the-board salary reduction may place VA in a non-competitive salary position in many locations, especially in those 100 locations where special salaries are in effect based on higher private sector pay rates.

Question 37. On page 5-16 of the fiscal year 1986 budget request, it indicates that the Office of Personnel and Labor Relations will assume full responsibility for the Central Examining Unit (CEU). What is the rationale for this change and, what, if any impact will this change have on the mission and operation of the CEU?

Answer 37. The Central Examining Unit (more correctly the special examining unit or SEU) conducts nationwide recruitment and competitive examining for psychologists, social workers, audiologists/speech pathologists, pharmacists, dietitians, occupational therapists, physical therapists, and medical records administrators. The unit was activated in October 1983 in response to a critical need for recruitment in these DM&S professional occupations.

Since 1980, the Office of Personnel Management (OPM) had undergone reorganization and staff reductions that severely limited its ability to support VAMC's recruitment needs. These recruitment problems had been documented in a major report to Congress in 1982. The report recommended establishment of an SEU in VA as a method of resolving the problem. DM&S and VA's Office of Personnel and Labor Relations (OP&LR), therefore, felt compelled to proceed with the unit's establishment.

VA's OP&LR entered into an interagency agreement with OPM to allow VA to conduct competitive examining in-house, but OP&LR was unable to obtain the needed funding and FTEE. Because the field's recruitment situation was continuing to deteriorate, DM&S set up the unit within medical care with the concurrence of OP&LR.

The rationale for transferring the SEU to OP&LR is that recruitment and examining are functions that should be performed by personnel staff.

Question 38. There has been some discussion about the pros and cons of "vertical" and "horizontal" reductions in order to achieve savings. Please define these terms, provide the Committee with several examples of each kind of reduction and state the advantages, disadvantages, and potential savings of each of these types of measures for medical care services.

Answer 38. The following two paragraphs provide an explanation of "vertical" and "horizontal reductions". In either case this represents a reduction of services provided.

A vertical reduction is defined as the discontinuation of a program or service or the closing of a facility. This could involve the elimination of a program or service nationwide, i.e., the domiciliary facility program or the closing of an entire facility. The advantages of this kind of a reduction are that while a program may be eliminated or a facility closed, the remainder of the system maintains its vitality, and the quality or integrity of the health care provided is not compromised. Achievable savings would vary tremendously based on what service, program or facility is eliminated.

A horizontal reduction can be defined as an across-the-board reduction. A ten percent reduction, for instance, could be applied across the board to all facilities. That is, each facility would receive an employment and funding level that reflects ten percent less resources.

The advantage of this approach is that everybody shares equally in the cut and the full range of services can still be provided. The disadvantage, is that across the board reductions could ultimately impact the quality of patient care, tending to strangle the system as a whole.

The utilization and impact of each of these methods varies. One consideration is the size of the resource reduction or absorption. Small reductions can be made horizontally (or across the board) without impacting the quality of health care. On the other hand, if substantial reductions are required, then the closing of facilities or elimination of programs (vertical reductions) must be considered. In either case, the decision process involves a determination of how to achieve the reduction and still provide quality health care to the greatest number of eligible veterans.

Question 39A. At the February 7, 1985, hearing before the House Hospitals and Health Care Subcommittee, Dr. John Ditzler stated that "eligibility" and "space availability" are two issues that we should "come to grips with".

What, in your opinion, is meant by the statutory term "within the limits of VA facilities" which appears in a number of places in Title 38, USC?

Answer 39A. Congress itself has made clear in its amendments to Chapter 17 contained in Public Law 94-581, the phrase ... "within the limits of VA facilities" means care and treatment primarily within the limits of existing resources, existing programs and existing facilities.

Question 39B. How is this different from "space availability"?

Answer 39B. The phrase above encompasses "space availability" only in a much broader sense. For example, ... space may be available, though equipment and resources are not.

Question 39C. What options, in addition to the enrollment plan which Dr. Ditzler mentioned in the House hearings would you suggest to deal with the "eligibility" and "space availability" issues?

Answer 39C. The Veterans Administration is planning to propose legislation that would authorize a means test for all nonservice-connected veterans except certain special categories of veterans and VA pension recipients. This proposal will assure that the VA's resources are focused on service-connected veterans, other special category veterans, and nonservice-connected veterans who are most in need of VA services. We have expanded various non-hospital, home, and outpatient treatment programs in the past few years. We anticipate the continuation of this trend with the resulting expansion of our ability to treat larger numbers of veterans in a more effective manner.

Question 40. In light of the availability of other Federal and State medical care assistance programs, overlapping eligibilities, and the astronomical costs of health care, have the VA, the Department of Health and Human Services, and other U.S. Departments and agencies engaged in any formal dialogues about the interrelationship of existing U.S. health care systems?

Answer 40. The White House Working Group on Health Policy and Economics, is the Executive group analyzing these issues. There are a number of others.

Question 40A. Who is the VA's representative to these discussions?

Answer 40A. Dr. John A. Gronvall, Deputy Chief Medical Director

Question 40B. What are the preliminary results of these meetings?

Answer 40B. The Working Group is still analyzing and assessing the complex issues and has not arrived at preliminary results.

Question 40C. What are your views about the role the VA should play, now and in the future, vis-a-vis other health care systems?

Answer 40C. The Veterans Administration is unique among federal health programs in that it is a provider of health care while others largely perform insurance functions. Since its inception, the Department of Medicine and Surgery has been dedicated to the care and treatment of eligible veterans and it is expected to maintain that role independent of other coverage.

Question 41. Do the projections for workload, staffing bed level, and services take into account the numbers of veterans who will be served if the proposed means test is implemented?

A. If not, will all the projections need to be reassessed and modified to reflect any changes resulting from implementation of the means test?

B. If so, for which fiscal years would this revision be required?

Answers 41A & B. The outyear projections for 1987 to 1990 (both resource and workload levels) assume enactment of a proposal to reform veteran eligibility requirements. The outyear estimates project that the impact of this reform would be an increase in the demand for nursing home and outpatient care and a decrease in short-term hospital care. The specific impact of this reform cannot be estimated at this time with any degree of certainty. Future budget submissions will provide better estimates based on more specific policy guidance and actual experience.

Question 42.

Veterans who seek care at VA medical facilities are generally viewed to be older, poorer and suffering from more chronic illness than patients found in the private sector. Please provide documentation substantiating or refuting this position.

Answer 42.

The best available data relating to this issue were obtained from the National Survey of Veterans (SOV II) conducted by the VA in 1979 and the Health Interview Survey (HIS) conducted by the National Center for Health Statistics in 1979-1981. SOV II provides information relating to the age and income levels of hospitalized veterans, and the HIS provides information regarding the types of illnesses treated in VA and non-VA hospitals.

Table 3.8, taken from SOV II, shows the age distribution of hospitalized veterans by type of hospital. It can be seen that there were slightly more veterans 45 and older hospitalized in VA hospitals than in non-VA hospitals, 74.7 percent and 71.6 percent respectively. (Comparisons for veterans under 45 are unreliable because of the smallness of the sample sizes.)

Table 3.9 (SOV II) provides a comparison of income levels of veterans discharged from VA and non-VA hospitals. It can be seen that there is a marked difference between VA veterans and non-VA veterans. Almost 60% of VA veterans had incomes under $10,000 whereas less than 20% of non-VA veterans had incomes under $10,000. Appendix D, Table 4 (SOV II) provides income data by age. The data show that in all age categories, including "65 and over", veterans hospitalized in VA facilities are significantly "poorer" (incomes under $10,000) than veterans hospitalized in non-VA facilities.

In regard to chronicity of illness, data are not available on "degree of chronicity", but the HIS provides data on diagnoses of veterans in VA and non-VA hospitals. Hence, the conclusions drawn from these data regarding chronicity are somewhat inferential. Table A-18 (HIS) provides data relating to the common discharges from short-stay VA hospitals and non-VA hospitals. When discharges of the conditions presumed to be chronic and marked** are totalled and then divided by total discharges (VA-1,626; non-VA, 11,467) the following percentages are obtained: VA-55%, non-VA-43%. It must be noted that these data apply to short-term hospitals only. HIS excluded over 30 VA hospitals that are by definition long-stay. It can be assumed, therefore, that if data from these long-stay hospitals were included in the calculations, VA hospitals would show an even larger percentage of patients with chronic conditions.

In summary, therefore, the best available data confirm the assertion that veterans in VA medical centers are older, poorer and suffering from more chronic conditions than veterans in non-VA hospitals. In regard to age, VA veterans have only a small edge over non-VA veterans. But in regard to income and chronicity, the data show very signficant differences between VA and non-VA hospitals, with VA veterans being by far poorer and more chronic than non-VA veterans.

Age and Income Distribution of Hospitalized Veterans

The age distribution of veterans hospitalized during 1978 is shown in table 3.8. 5/ The age distribution of veterans hospitalized in non-VA hospitals is not substantially different from that of veterans hospitalized in VA medical centers.

Table 3.8
Percentage Distribution of Age of Veterans Hospitalized in 1978 by Type of Hospital

	All Hospitals	VA Medical Centers	Non-VA Hospitals
All Ages (in thousands)	3,855	513	3,405
Percent	100.0	100.0	100.0
Less than 25	2.7	6.5*	2.0
25-34	12.7	11.3*	12.9
35-44	12.6	7.5*	13.5
45-54	26.0	28.0	25.9
55-64	30.4	31.9	29.9
65 and over	15.6	14.8	15.8

*Estimate has large sampling variability due to the small number of sample persons in the cell.

Note: 69,000 veterans used both VA and non-VA hospials, therefore they are included in both VA medical centers and in non-VA hospitals.

5/ The older veterans (age 50 and over) were oversampled so that more statistically reliable data would be available for that group.

SOURCE: VETERANS ADMINISTRATION
National Survey of Veterans (1979)

Table 3.9 shows family income distributions for veterans hospitalized in VA medical centers and those hospitalized in non-VA hospitals. Almost 60 percent of the veterans with VA hospital episodes during 1978 had family incomes under $10,000 while less than 20 percent of the veterans with non-VA hospital episodes had incomes that low. The relatively large percentage of lower income veterans in VA medical centers is due, at least in part, to the eligibility criteria. Veterans in the third eligibility category (see "eligibility" paragraph earlier in this section) must state under oath that they are unable to defray the cost of necessary hospital charges elsewhere unless they are 65 years of age or older or are in receipt of VA pension. Both those age 65 and over and those in receipt of VA pension are apt to have lower incomes.

Table 3.9
Percent Distribution of Income of Veterans Hospitalized in 1978 by Type of Hospital

	VA Medical Centers	Non-VA Hospitals
All Incomes (in thousands)	513	3,405
Percent	100.0	100.0
Less than $ 5,000	22.6	6.2
$ 5,000 - $ 9,999	35.3	13.6
$10,000 - $14,999	12.7	17.4
$15,000 - $19,999	13.0	15.5
$20,000 - $24,999	6.8*	15.2
$25,000 and over	4.2*	26.2

*Estimate has large sampling variability due to the small number of sample persons in the cell.

Note: 69,000 veterans used both VA and non-VA hospitals, therefore they are included in both VA medical centers and in non-VA hospitals.

Family income is used in this table (Question 35, see Appendix B).

Appendix D, Tables 1 through 4 provide additional information on hospitalization for text Tables 3.1, 3.4, 3.6, and 3.9.

SOURCE: VETERANS ADMINISTRATION
National Survey of Veterans (1979)

Appendix D, Table 4

Percent Distribution of Income of Veterans Hospitalized in 1978 by Age and Type of Hospital

Income	All Ages		Under 35		35 to 64		65 and Over	
	VA Medical Centers	Non-VA Hospital	VA Medical Centers	Non-VA Hospital	VA Medical Centers	Non-VA Hospital	VA Medical Centers	Non-VA Hospital
All Incomes (in thousands)	513	3,405	92	510	345	2,359	76	537
Percent	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Less than $ 5,000	22.6	6.2	9.4	5.5	24.0	4.0	32.5	16.8
$ 5,000 - $ 9,999	35.3	13.6	41.9	12.8	32.3	9.9	40.6	30.7
$10,000 - $14,999	12.7	17.4	9.2	29.0	13.9	14.7	11.5	18.1
$15,000 - $19,999	13.0	15.5	22.3	19.0	12.4	16.1	4.6	9.8
$20,000 - $24,999	6.8	15.2	9.0	17.1	7.7	16.6	0.0	7.2
$25,000 and over	4.2	26.2	8.3	14.8	3.1	32.0	4.3	11.3
Unknown	5.4	5.9	0.0	1.9	6.6	6.7	6.6	6.0

Note: 69,000 veterans used both VA and non-VA hospitals, therefore, they are included in both VA medical centers and in non-VA hospitals.

SOURCE: VETERANS ADMINISTRATION
National Survey of Veterans (1979)

Appendix Table A-18 (cont'd)
Length of Stay of Hospitalization Among Veterans in VA Hospitals and All Other Hospitals by Condition, From the Health Interview Survey, 1979-1981.

	VA Hospitals			All Other Hospitals		
	Hospital Discharges (in thousands)	Total Hospital Days (in millions)	Days per Episode	Hospital Discharges (in thousands)	Total Hospital Days (in millions)	Days per Episode
ALL CONDITIONS	1,626	33.1	20.4	11,467	103.5	9.0
Infective & Parasitic Diseases	33*	0.4*	12.1*	139	0.9	6.5
Malignant, Benign & Unspecified Neoplasms	** 113	1.7	15.0	** 732	6.4	8.7
Diabetes, & Other Endocrine, Nutritional & Metabolic Conditions	46*	2.0	43.5*	285	3.1	10.9
Mental & Personality Disorders & Deficiencies	** 157	7.3	46.5	** 289	4.9	17.0
Cerebrovascular Disease	** 42*	0.8*	19.0*	** 228	3.6	15.8
Diseases of the Nervous System & Sense Organs	** 51*	0.4*	7.8*	** 345	3.8	11.0
Heart Diseases	** 205	3.5	17.1	** 1,571	14.0	8.9
Other Circulatory Diseases	** 146	4.2	28.8	** 750	6.7	8.9
Respiratory Conditions	** 173	3.1	17.9	** 995	8.3	8.3
Ulcer of Stomach & Duodenum	29*	0.3*	10.3*	294	2.9	9.9
Hernia	51	0.4*	7.8*	586	2.9	4.9
All Other Digestive System Diseases	120	2.2	18.3	927	9.5	10.2
Male Genital Disorders	44*	0.6*	13.6*	332	2.9	8.7
Diseases of Eye & Visual Impairments	47*	0.5*	10.6*	290	1.2	4.1
All Other Genitourinary System Conditions	49*	0.6*	12.2*	633	3.4	5.4
Diseases of the Skin	16*	0.2*	12.5*	132	1.0*	7.6*
Arthritis, All Forms; Other Diseases of Bones & Joints, & All Other Diseases of the Musculoskeletal System	90	2.5	27.8	761	5.4	7.1
Fractures & Dislocations	49*	0.9*	18.4*	558	7.7	13.8
All Other Current Injuries	113	2.1	18.6	1,127	12.0	10.6
All Other Conditions & Observations	54*	0.4*	7.4*	490	3.2	6.5

*Relative standard error of 30% or more.

** Denotes Chronic Condition

SOURCE: National Center for Health Statistics
Health Interview Survey

Question 42A.

What percentage of veterans currently eligible for VA medical care would therefore be subject to the proposed means test?

Answer 42A. Most veterans are potentially eligible for VA medical care. The means test proposed is intended to ensure that the VA's primary mission—to care for service-connected, special categories (Agent Orange, POW, Atomic, etc.), and poor veterans—is met. We estimate there are approximately 11.03 million veterans in the "mandatory" group, i.e., those who whould not be subject to the means test. This estimate includes NSC veterans over age 65 with limited incomes. Therefore, approximately 16 million of the 28 million veterans would be subject to the means test. The VA treats approximately 2.9 million veterans, 1.5 million of which are service-connected, and the remainder are other mandatory (Agent Orange, etc.) or nonservice-connected. Of this population, we estimate that about 48,000 individuals would be required to seek care from private sector sources. After spending their expected medical payments, they could then be eligible for care in VA facilities.

Question 42B.

What specific demographic and other information do you have about this group of veterans, including information related to age, income, medical needs, and alternative options, such as private health insurance, Medicare and Medicaid, for receiving medical care?

Answer 42B. Of the approximately 16 million veterans who could be subject to the means test we do not have specific information as requested. However, the following table from the VA's 1979 National Survey of Veterans indicates that a vast majority of veterans have some kind of health insurance:

TABLE 3.24

Percent of Veterans by Type of Health Insurance
Benefits and Service-Connected Disability
Status, 1978

	All Veterans	Service-Connected Disiability	No Service-Connected Disability
Number (in thousands)**	29,164	3,019	26,085
Percent	100.0	100.0	100.0
Yes, Have Health Ins.	89.1	80.8	90.2
Individual Health Ins.	(16.7)	(15.2)	(16.9)
Group Plan (i.e., Employer, Union, etc.)	(70.9)	(55.7)	(72.7)
Health Maintenance Organization	(1.8)	(1.8)*	(1.8)
Medicare, Part A	(9.6)	(18.4)	(8.6)
Medicare, Part B	(8.7)	(16.1)	(7.9)
Medicaid or Medical Assistance	(1.1)	(1.4)*	(1.0)
CHAMPUS or CHAMPVA	(2.2)	(5.2)	(1.8)
Other	(0.7)	(1.2)*	(0.6)
No Health Insurance	10.8	19.2	9.8
Unknown	0.1*	0.0	0.0

*Estimate has large sampling variability due to small numbers.

** 0.2 percent of the veterans had an unknown service disability status.

NOTE: Percent with insurance is less than the sum of percents by type of coverage due to multiple insurance coverage for some veterans.

Question 42C. What impact will the means test have on the combination or mix of veterans who will receive VA health care services?

Answer 42C. The means test will permit the VA health care capacity to be directed toward service connected veterans, former POWs, veterans exposed to Agent Orange or ionizing radiation, pensioners, WWI, Spanish American War, Mexican border period, and other nonservice connected veterans who are truly needy.

Question 42D.

Will the veterans be more or less of a homogeneous group; will they have medical needs different from patients currently served by the VA; and will they require different kinds and levels of services?

Answer 42D.

We anticipate no change in the different needs, kinds and levels of services that are now provided VA patients.

Question 43.

What specific efforts have been initiated or planned to examine other Federal or State means-tested programs, such as Medicaid, so that the VA may draw from the experiences of these programs in order to implement the proposed means test in a fair and reasonable way?

Answer 43.

No specific efforts have been undertaken to examine other Federal or State means tested programs, such as Medicaid because of the fundamental differences in the programs. The VA is a health delivery system whereas Medicaid is a health insurance system. We have closely reviewed the VA pension program and its process for determining eligibility. It is our intention to model the means test along the lines of the VA pension program process.

Question 44.

To what extent do you believe that the means test would result in cost shifting from the VA to other Federal or State supported medical programs, such as Medicare and Medicaid?

Answer 44.

It is our belief that the means test will not result in any cost shifting to Medicaid in as much as patients eligible for Medicaid would be eligible for VA care.

Question 45A. On November 27, 1984, Dr. John Ditzler provided the former Chairman of the Committee, Senator Alan K. Simpson, with the 4th quarter status report for fiscal year 1984, of the Department of Medicine and Surgery's billing action of those employees identified in the Inspector General's 1979 audit.

Of 449 bills prepared, 132 bills amounting to $150,008, were paid, and 171 waivers totaling $433,750, were waived. Why was such a large number of waivers granted?

Answer 45A. The IG Audit identified 465 VA employees who were nonservice-connected veterans, had incomes of $15,000 or more a year, and had government-sponsored health insurance plans. All 465 veterans were allegedly treated for nonservice-connected medical problems, and their entitlement to cost-free VA care was solely contingent upon their inability to defray the costs of hospital and medical services from the private sector. Based on the factors of income and health insurance coverage, the Inspector General concluded that the 465 VA employees did not reasonably satisfy the inability-to-defray eligibility criterion, and therefore, should be billed for the services provided to them.

After the veteran was billed, he/she would either request a waiver, compromise, or appeal the basis of the billing. When a waiver was requested, the veteran completed a financial statement and the Fiscal Officer sent the information to the Committee on Waivers and Compromises at the appropriate VA Regional Office for review and discussion. The Committee's determination had two stages. First the committee determined if the "individual was with material fault." This was determined by asking the question "Did the individual know or should he/she have known that he/she was not eligible?" If the answer to this question was yes, then the case was not waiverable. If the answer was no, then the committee reviewed the financial statement and made their decision whether to grant the waiver. If the waiver was denied, the decision was then appealable to the Board of Veterans Appeals. Under this procedure each individual case was reviewed on its own merit and 171 waivers granted.

Question 45B. What, if any, changes in the current billing process would be required in order to implement the proposal to require third party reimbursement from private sector insurers for care provided to certain veterans?

Answer 45B. If legislation is passed removing the exclusionary clause from private health insurance policies, the VA would need an automated billing system to handle the volume of bills that are expected. The existing manual system could not handle the expected workload. Various options, including in-house ADP development as well as contracting, are being considered for future implementation.

Question 46.

Preliminary General Accounting Office information indicates that in 1982, the VA could have recovered from $98 to $284 million from private health insurers while only incurring about 1.7 million in administrative costs. The VA budget request estimates potential cost recoveries form third party payers to be only $65 million.

What are your views on these and other findings in the GAO report and what, in your opinion, accounts for the large difference in VA and GAO savings estimates?

Answer 46. Administrative cost estimates are being developed and will be submitted with our legislative proposal.

Questions 47A, B, & C.

In his October 30, 1984, remarks, "State of the Department: The Future", at the Department of Medicine and Surgery (DM&S) Annual Conference of VA Medical Center Directors and Chiefs of Staff, Dr. John Ditzler suggested that quality assurance is "an area we must effectively emphasize and to that end, I will propose appointing an ACMD for quality assurance".

A. Have you appointed an ACMD for Quality Assurance?
B. If not, do you intend to do so?
C. If so, what is the time for some making this appointment?

Answers 47A, B, & C.

The Department's nomination of a candidate for the position of Director, Office of Quality Assurance, has been forwarded to the Administrator for approval. No problems are anticipated.

Question 47D. **Please describe any other Quality Assurance efforts initiated or planned since the Committee's June 6, 1984, hearing on VA quality assurance programs.**

Answer 47D. **The Medical District Initiated Peer Review Organization (MEDIPRO) program was approved by the Acting Chief Medical Director in October 1984 based on a set of recommendations developed by a peer review field advisory committee. MEDIPRO is one of the fundamental elements of the Chief Medical Director's Strategic Management Process which includes staffing standards, resource allocation systems, and planning (MEDIPP). A pilot test of the MEDIPRO program is scheduled to begin this fiscal year.**

When fully implemented on a national scale, the MEDIPRO program will function at the Medical District level with professional staff primarily performing analytical activities based on quality and utilization data from the medical centers within the District. Physician reviewers will conduct indepth chart reviews of cases identified during the analytical review to determine if the quality of patient care was adequate and that services provided were necessary and appropriate. A MEDIPRO Board of physicians and dentists from each VAMC in the District will set priorities, approve review criteria, oversee the peer review program, and assure followup of problems. The Regional Directors will have operational responsibility for MEDIPRO, including taking necessary actions resulting from District review findings and assuring that effective reviews are accomplished. The Office of Quality Assurance will provide policy, guidance, and technical assistance and will monitor and evaluate the effectiveness of the program.

Question 47E. Please list the resources (including dollars, FTEE, and travel funds) that were provided in fiscal year 1983 and 1984 and that will be provided in fiscal years 1985 and 1986 for quality assurance activities, including, but not limited to the following activities:

- Office of the ACMD for Quality Assurance
  - Medical District Initiated Peer Review Organization (MEDIPRO)
  - Systematic External Review Program (SERP)
  - Reports Management Activities
  - Patient Satisfaction Survey
  - Health System Review Organization (HSRO)
- Regional Office Specialists (devoted fulltime to QA)
- Systematic Internal Review (SIR) Program
  - HSRO Coordinators (devoted fulltime to quality assurance activities)
- Educational Programs on Quality Assurance

Answer 47E. Resources provided or projected for Quality Assurance activities in the four fiscal years (except the Educational Programs on Quality Assurance) includes:

FY 1983: $317,085 Funds and 32 FTEE
FY 1984: $315,602 Funds and 31 FTEE
FY 1985: $323,623 Funds and 31 FTEE
FY 1986: $264,623 Funds and 31 FTEE

There are no Health System Specialists in Regional Offices devoted fulltime to Quality Assurance activities.

There are approximately 63 HSRO Coordinators (devoting fulltime to quality assurance activities) in VA medical centers.

Resources provided or projected for Quality Assurance education activities in the four fiscal years requested includes:

	RMEC FUNDING	OTHER QA or RELATED TRAINING
FY 1983:	$ 85,893	0
FY 1984:	$103,373	$115,000 (QA & A-123)
FY 1985:	$101,246	$ 30,000 projected
FY 1986:	$ 86,000	$ 27,000 projected

-- Activities pertaining to medical investigations

1983 - $25,436

1984 - $30,006

1985 - $37,000

1986 - Not known at this time.

Question 48A. A February 1, 1985, letter, submitted pursuant to the requirements of section 210(b)(2) of title 38, United States Code, described a plan for and justification of a proposed prosthetics reorganization.

Please provide a detailed plan and justification for the resources (including both dollars and FTEE) that will be required to implement the reorganization.

Answer 48A. This reorganization provides the Department, as well as the Agency, a consolidated organization responsible for management and coordination of those activities related to prosthetics, including research and development. Organizationally consolidating these activities under the direction of a single manager will facilitate the delivery of high quality care and at the same time provide a focal point for development of new and better devices and services. Three (3) FTEE will be required for the office of the Deputy ACMD for Prosthetics Services. Research and Development: one Deputy ACMD, one Health Systems Specialist, and one secretary. Personal Services cost for these positions will be approximately $163,318 per annum. Other cost will involve relocation of some positions from the New York City area to the Washington, D. C. area. The approximate cost will be $180,000. Some equipment will also be moved to the Washington, D. C. area at an approximate cost of $30,000. These costs will be provided from within existing resources.

Question 48B. Please provide a description of the construction needs, a list of the construction resources (including dollars) to be allocated, and a prospectus describing the construction plans for the proposed Prosthetics Assessment and Information Center (PAIC).

Answer 48B. The need is to construct a building at the VAMC Washington, D. C. to house the PAIC and some components of the Rehabilitation Research and Development Service. Approximately 16,000 square feet will be needed at a cost of less than $2.0 million. A prospectus describing the construction plans has not been formulated at this time. A copy will be sent as soon as available.

Question 48C. What, if any, additional construction resources will be required in the future for the Prosthetics Assessment and Information Center?

Answer 48C. No additional construction costs are anticipated in the future for the PAIC.

Questions 48D & E. Please submit a list of the resources devoted to each of the organizational components listed on attachment 1 of the reorganization plan for fiscal year 1984 and anticipated for fiscal year 1985.

Please submit a list of the resources to be devoted to each of the organizational components listed on attachment 2 of the reorganization plan for fiscal year 1986.

Answers 48D & E. The organizational chart on attachment 1 reflects the structure of PETIC & Rehabilitation Research & Development (RR&D) before the reorganization. The reorganization will place the PETIC portion of Prosthetic & Sensory Aids Service (PSAS), with the exception of the Clinical Services and the Orthopedic Shoe Service, under the new Deputy and located at the Washington VA Medical Center. PSAS and RR&D will also be under the new Deputy and remain in Central Office. In addition, the STAMP program which was established in FY 1984 will be placed under the new Deputy and remain in Central Office. The resources required in the reorganization are answered in Question 22a.

Question 48F. Please provide a copy of the Memorandum of Understanding developed and jointly agreed upon by the ACMD for Research and Development and the ACMD for Professional Services outlining internal operating procedures concerning the Research budget.

Answer 48F. Copy of Memorandum of Understanding is attached.

MEMORANDUM OF UNDERSTANDING
BETWEEN
ACMD FOR PROFESSIONAL SERVICES
AND
ACMD FOR RESEARCH AND DEVELOPMENT

I. PURPOSE

The purpose of this Memorandum of Understanding is to identify specific responsibilities of the ACMD for Professional Services and the ACMD for Research and Development to ensure that the Rehabilitation Research and Development (Rehab R&D) program most effectively meets its assigned mission and the goals of improved operations sought by the organizational reassignment of the Rehab R&D Service to the ACMD for Professional Services in the reorganization of Prosthetics.

II. BACKGROUND

The decision has been made by the Administrator of the Veterans Administration to transfer the Rehabilitation Research ano Development Service from the Office of the ACMD for R&D to the Office of the ACMD for Professional Services.

The R&D program in the field is administered at the local VAMC by the Associate Chief of Staff (ACOS) for R&D under the direction of the Medical Center Director. The ACOS/R&D is responsible at the local level for the administrative and budgetary operations of R&D. The ACOS/R&D position is centralized to the ACMD for R&D. Programmatic actions that the Rehab R&D Service now effects directly, will have to be routed through the Deputy ACMD for Prosthetics Services, Research and Development, the ACMD for Professional Services to the ACMD for R&D for concurrence.

III. ACMD FOR R&D RESPONSIBILITIES

A. Delegated in accordance with CMD Memorandum 10-83-33 authority for the Director, Rehab R&D Service to sign over own name and title "By Direction of the Associate Deputy Chief Medical Director," the following correspondence:

1. All communications pertaining to personnel, equipment, supplies and programs supported by research funds. Concurrence of the Director, Office of Procurement and Supply is required when centrally controlled equipment or supplies are involved. Concurrence of the Director, Facility Engineering, Planning, and Construction Office, is required when non-recurring maintenance and repair projects are involved. Copies of communications to field facilities will be sent to the appropriate Regional Director and other affected staff offices.

2. Letters of Agreement covering services rendered to R&D.

B. Submitting annually the Rehab R&D budget and implementing subsequent adjustments from within the Agency, OMB and Congress.

C. Developing a fiscal plan and maintaining operations of the Rehab R&D budget.

D. Coordinating the planning and budget operations with the ACMD for Professional Services.

IV. ACMD FOR PROFESSIONAL SERVICES RESPONSIBILITIES

A. Conducting administrative and programmatic operations of the Rehab R&D Service.

B. Submitting the annual budget plan developed by the Director, Rehab R&D Service and the DACMD/PS, R&D to the ACMD for R&D for incorporation into the R&D budget.

C. Submitting to the ACMD for R&D for processing budgetary adjustments within a project, such as withdrawal or addition of funds.

D. Meeting at least quarterly with the ACMD/R&D to review the Rehab R&D budget to assure its consistency with the plan.

V. STANDARD OPERATING PROCEDURES

(A) The Director of the Rehab R&D Service will report directly to the DACMD/PS, R&D for all aspects of the Rehab R&D Operation, both budgetary and programmatic. All budget actions relating to the Rehab R&D program will be forwarded through the DACMD/PS, R&D for concurrence prior to being forwarded to the ACMD for Professional Services and to the ACMD for R&D for review and implementation.

(B) The intent of this operating procedure is to insure that responsible program officials provide adequate budgetary information concerning the Rehab R&D program so that necessary funding can be provided to meet program goals and objectives. This goal is shared by the DACMD for Prosthetics Services, Research and Development, the ACMD for Professional Services, and the ACMD for Research and Development. To accomplish this goal, the Director, Rehab R&D Service will submit through the ACMD for Professional Services to the ACMD for R&D a budget plan for program operations when required which represents the planned spending for the upcoming fiscal year. The plan will consist of two sections: The first section will include a narrative describing the on-going program priority areas, the program plans for new initiatives and administrative actions (site visits, state of the art conferences and merit review board meetings); the second section will contain the budget figures and statistical data concerning the on-going merit review projects, the Centers and Units, the Interagency Agreements and contracts, FTEE distribution and the planned costs (new merit reviewed projects, etc.) for the entire fiscal year.

(C) The budget plan and all budget actions will be submitted by the Director, Rehab R&D Service through the DACMD for Prosthetics Services, Research and Development and the ACMD for Professional Services, to the ACMD for Research and Development for review and implementation. Any problem areas that arise in this process which cannot be resolved satisfactorily by the parties involved, will be forwarded to the Associate Deputy CMD for decision.

(D) The above agreement will be referred to as an interim operating procedure to insure the success of the reorganization.

BY: Hollis G. Boren
HOLLIS G. BOREN, M.D.
ACMD for Research and Development

DATE: 10-3-84

BY: Carl W Hughes M.D.
CARL W. HUGHES, M.D.
ACMD for Professional Services

DATE: 10-3-84

APPROVED: D. Earl Brown Jr
D. EARL BROWN, JR., M.D.
Associate Deputy Chief
Medical Director

Question 49. In the VA's Medical, Prosthetic and Health Services Research budgets, it appears that there is a $5 million decrease in your request. Please explain the reason for the reduction and provide a breakdown in each of the areas, medical, prosthetic and health services research.

Answer 49. The $5 million decrease includes savings resulting from salary reduction for Federal employees. This reduction would be applied to medical, prosthetics and health services research in proportion to the personal services dollars in each program account. For Medical Research Service, the proposed budget will result in reduction of approximately 40 investigator initiated research programs, 15 Career Development programs, 1 Cooperative Study and 6 High Priority programs.

The Health Services Research and Development Service budget for FY 86 represents the current services level, incorporating the decrease projected as a result of the proposed 5% pay reduction and increases for inflation. The following actions will permit continuation of a sound basic program, although the indicated potential new activities can only be supported as ongoing efforts are terminated.

Investigator-Initiated Research

- Continue to support 45 investigator-initiated research projects. We estimate that an additional fifteen planned, scientifically valid studies that VA program officials judged highly relevant to VA health care problems will remain unfunded.

- Field Programs: Continue to fund 10 existing Regional Field Programs, including 3 system-wide resource programs in selected priority areas: care of the aging (Seattle); ambulatory care/prevention (Durham); and improving health care operations (Ann Arbor); support doctoral-level training for VA-relevant research at each of these three sites, plus District 17. Two additional needed programs and one needed system-wide resource cannot be established.

- Special Projects: Continue to support the HSR&D Special Projects Office. The Special Survey to determine veterns' demand for VA medical care will be repeated.

The Rehabilitation Research and Development (Rehab R&D) Service conducts the prosthetic research program. The Rehab R&D Service FY '86 budget increased $815,000 for increased costs associated with inflation, payroll adjustments and the FY 1985 pay raise; it had decreased costs of $259,000 for the 5% pay cut planned in FY 1986, the overall FY 1986 budget increase for the Rehab R&D Service is $555,000.

Overall, the Rehab R&D Service will strive in FY 1986 to continue those projects underway, to preserve program continuity, and to prevent any loss of both dollars and time already invested in these projects. The only new projects begun in FY 1986 will be those which can be funded when older projects reach their conclusions and the funds originally allocated to the older projects are available. This natural ending of projects can be expected to occur in about 10% of the total number of projects, which is approximately 143 for FY 1985.

Question 50. The fiscal year 1986 budget request provides for 172 FTEE at each medical center for occupational safety and health monitoring. Will these 172 FTEE be industrial hygiene specialists or fire and safety engineers?

Answer 50. A specific purpose for this request is to expand the availability of industrial hygiene expertise throughout the VA. VA has been criticized by OSHA in four (4) successive program evaluations for a lack of industrial hygiene expertise.

Not all 172 FTEE will be industrial hygienists. These specialists are scarce. VA could probably not recruit 172 of them in one year. Additionally, other types of technical and managerial expertise are needed to provide for a fully functional occupational safety and health program. Therefore, the additional 172 FTEE will be comprised of a variety of health and safety specialists, including fire and safety engineers, where needed. The primary focus in filling the requested positions will be on occupational safety and health categories, however, as opposed to fire and safety engineers.

Question 51. Please provide a breakdown, by provision, of the resources (including dollars and FTEE) allocated to implement the provision of Public Law 98-528, the Veterans Health Care Act of 1984.

Answer 51. The Veterans Administration Health Care Improvements Act of 1984 (Public law 98-528) provided a range of improvements to the health care programs and authority to improve security at VA facilities. The chart below provides the dollars and FTEE associated with the various provisions of this law for 1985. Except where noted additional funding was not provided to specifically support provisions of this law. The provisions will be funded assuming availability of existing resources.

Veterans Health Care Act of 1984
(dollars in thousands)

	FY1985
Sec. 101 - Security and Law Enforcement........................	$ 957
Sec. 103 - Contract Health Care in Puerto Rico/Virgin Islands 1/.......	9,000
Sec. 104 - Extension of GRECC Activities 1/........................	11,972
FTEE..............................	231
Sec. 105 - Properties for State Veterans Homes........................	*
Sec. 106 - Coordination of State and Local Programs......................	*
Sec. 107 - Medical and Rehabilitative Devices.................	528
Sec. 108 - Pay Rate Adjustment for Certain Psychologists.............	*
Sec. 110 - Post Traumatic Stress Disorder 2/.........................	3,532
FTEE..............................	85
Sec. 111 - Alcohol and Drug Treatment and Rehabilitation Guidelines.........	*
Sec. 201 - Report on VA Programs for Terminally Ill.....................	166
FTEE..............................	4
Sec. 202 - Veterans Residing in Remote Georgraphic Areas..............	*
Sec. 302 -	
a. Rename Murfreesboro VAMC	17
b. Rename Wood VAMC	21

* No costs are associated with this provision.

1/ Resources supporting this provision in 1985 are included in the existing appropriation.

2/ Exludes resources included in the existing appropriation supporting the 10 existing PTSD centers. The $3,532,000 and 85 FTEE are distributed as follows:

	$(000)	FTEE
- Congressional add-on supporting the National PTSD center, 2 new centers and augment 10 existing centers.......	$2,600	70
- Other: resources associated with the training requirements included in the provision as well as administrative support for the PTSD Special Committee and the PTSD study to Congress (not included in recurring base).......................	932	15
Total................................	$3,532	85

Question 52. Please provide a summary of all efforts initiated and planned to implement title II of Public Law 98-160, the Veterans' Health Care Amendments of 1983.

Answer 52. All policies to implement Title II of Public Law 98-160 are either now in place in Agency personnel directives, or are awaiting imminent approval by the Administrator.

A policy circular to implement section 203 of the law, concerning veteran preference, was approved May 16, 1984, and was published in the Federal Register on June 6, 1984. Section 206, concerning appointment of health care employees at salary steps above the minimum for the grade, was implemented on January 23, 1985, and is now being applied at VA Medical Centers. The remaining sections of Title II, concerning licensed physical therapists, licensed practical nurses, and certified or registered respiratory therapists, will be implemented within the next few weeks.

Question 53. Please provide a breakdown of the resources allocated to the pilot program for the treatment of veterans with alcohol and drug abuse related disabilities during each of its 5 years of operation including:

A. the number of veterans participating in the program;

B. the numbers and locations of contracts awarded, and

C. the dollars expended.

Answers. See attached

PILOT CONTRACT PROGRAM FOR ALCOHOL AND/OR DRUG DEPENDENCE TREATMENT AND/OR REHABILITATION

FACT SHEET

	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985
TOTAL RESOURCE ALLOCATION	$ 5,059,200	$ 6,609,600	$ 6,147,200	$ 6,286,644	$ 6,100,000
1st Qtr Utilization	$ 107,180	$ 731,261	$ 1,075,277	$ 1,494,567	$ 1,674,415*
2nd Qtr Utilization	$ 245,161	$ 816,593	$ 1,166,795	$ 1,580,318	$
3rd Qtr Utilization	$ 400,394	$ 874,759	$ 1,192.985	$ 1,672,249	$
4th Qtr Utilization	$ 558,441	$ 909,565	$ 1,259,048	$ 1,446,875	$
TOTAL RESOURCE UTILIZATION	$ 1,311,176	$ 3,332,178	$ 4,694,105	$ 6,194,009	$ 6,697,660**
FUNDED VAMC's	67	74	79	83	89
APPROVED CONTRACTS	150	202	252	296	303
1st Qtr Admissions	176	933	1,197	1,421	1,440*
2nd Qtr Admissions	375	968	1,269	1,612	
3rd Qtr Admissions	567	1,101	1,273	1,388	
4th Qtr Admissions	757	1,134	1,256	1,269	
TOTAL ADMISSIONS	1,875	4,045	4,995	5,690	5,760**
TOTAL DISCHARGES	1,498	3,778	4,682	5,469	

* Data incomplete at this time. Reports still being collated.

** Projected figures

MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE

LIST OF CONTRACT FACILITIES
IN ORDER OF CONTRACTING VAMC

CONTRACT STATUS

FY 1985

OBS	STATION	VACO ID	CONTRACT FACILITY	VACO APPROVAL
1	ALBANY, NY	500-01	ST. PETER'S ALCOHOL REHABILITATION CENTER	09/04/84
2	ALBUQUERQUE, NM	501-01	LAPASADA HALFWAY HOUSE	09/04/84
3	ALLEN PARK, MI	553-01	JELLEMA HOUSE	09/19/84
4	AMERICAN LAKE, WA	505-01	TAMARC, INC.	09/06/84
5	AMERICAN LAKE, WA	505-02	PIONEER HUMAN SERVICES	09/06/84
6	ANCHORAGE, AK	363-01	FAIRBANKS NATIVE ASSOCIATION	09/12/84
7	ANCHORAGE, AK	363-02	GASTINEAU MANOR	12/28/84
8	ANCHORAGE, AK	363-03	TRANSITION HOUSE	12/28/84
9	ATLANTA, GA	508-01	DECOPOLIS, INC.	09/10/84
10	ATLANTA, GA	508-02	MIDWAY REHABILITATION CENTER	09/19/84
11	AUGUSTA, GA	509-01	AIKEN COUNTY COMMISSION ON ALCOHOL AND DRUG ABUSE	09/04/84
12	AUGUSTA, GA	509-01	DAWN CENTER HALFWAY HOUSE	12/17/84
13	BALTIMORE, MD	512-01	GALE HOUSE	09/28/84
14	BATH, NY	514-01	CROSSROADS HALFWAY HOUSE (ALPHONSE)	02/05/85
15	BATH, NY	514-02	CROSSROADS HALFWAY HOUSE (ALEXANDER)	02/05/85
16	BATH, NY	514-03	SYRACUSE BRICK HOUSE, INC.	02/05/85
17	BATTLE CREEK, MI	515-01	JELLEMA HOUSE	09/12/84
18	BATTLE CREEK, MI	515-02	FAYETTE STREET HOUSE	09/12/84
19	BATTLE CREEK, MI	515-03	HARDER HOUSE	09/12/84
20	BATTLE CREEK, MI	515-04	LIFE HOUSE	09/19/84
21	BAY PINES, FL	516-01	PINELLAS COMPREHENSIVE ALCOHOL SERVICES, INC.	09/06/84
22	BIG SPRING, TX	519-01	MIDWAY HALFWAY HOUSE	09/18/84
23	BIG SPRING, TX	519-02	CLOVER HOUSE	09/18/84
24	BIG SPRING, TX	519-03	PARRISH HOUSE	09/18/84

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25	BIG SPRING, TX	519-04	SAN ANGELO HALFWAY HOUSE	09/18/84
26	BIG SPRING, TX	519-05	WALKER HOUSE, INC.	09/18/84
27	BIG SPRING, TX	519-06	CASA BLANCO HALFWAY HOUSE	09/18/84
28	BILOXI, MS	520-02	LAKEVIEW CENTER, INC.	09/13/84
29	BILOXI, MS	520-03	THE GREEN HOUSE	09/13/84
30	BILOXI, MS	520-05	BRIDGE HOUSE	09/13/84
31	BILOXI, MS	520-06	BRIDGE HOUSE	09/25/84
32	BILOXI, MS	520-07	DAUPHIN WAY LODGE	09/28/84
33	BOISE, ID	531-02	PORT OF HOPE CENTER	09/27/84
34	BOISE, ID	531-03	SALVATION ARMY	09/27/84
35	BOISE, ID	531-04	PORT OF HOPE, TWIN FALLS	10/10/84
36	BOSTON, MA	523-01	HOPE HOUSE, INC.	09/06/84
37	BOSTON, MA	523-02	CASPER HOUSE	09/06/84
38	BOSTON, MA	523-03	HELLO HOUSE	09/06/84
39	BOSTON, MA	523-04	SALVATION ARMY HARBOR LIGHT CENTER	09/06/84
40	BROCKTON, MA	525-01	THE RECOVERY HOUSE	09/11/84
41	BROCKTON, MA	525-02	THE NORTH COTTAGE PROGRAM	09/11/84
42	BROCKTON, MA	525-03	ROBERT J. WILSON HOUSE	09/18/84
43	BUFFALO, NY	528-01	HIAWATHA MANOR	09/04/84
44	BUFFALO, NY	528-02	FELLOWSHIP HOUSE	09/04/84
45	BUTLER, PA	529-01	DONOFRIO HOME	09/10/84
46	BUTLER, PA	529-02	BUTLER ALCOHOLISM RECOVERY CENTER, INC.	09/10/84
47	BUTLER, PA	529-04	LACASA HALFWAY HOUSE	09/10/84
48	CANANDAIGUA, NY	532-01	FLACRA	09/11/84

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49	CANANDAIGUA, NY	532-02	SYRACUSE BRICK HOUSE, INC.	09/11/84
50	CANANDAIGUA, NY	532-03	CROSSROADS HALFWAY HOUSE (ALEXANDER)	09/11/84
51	CANANDAIGUA, NY	532-04	CROSSROADS HALFWAY HOUSE (ALPHONSE)	09/11/84
52	CANANDAIGUA, NY	532-05	LOREMORE HALFWAY HOUSE	09/11/84
53	CHARLESTON, SC	534-02	OUR PLACE	09/19/84
54	CHARLESTON, SC	634-01	PHOENIX RESIDENTIAL COMMUNITY	09/19/84
55	CHEYENNE, WY	442-01	SHERIDAN HALFWAY HOUSE	09/06/84
56	CHEYENNE, WY	442-02	CHEYENNE HALFWAY HOUSE	09/06/84
57	CHICAGO (WS), IL	537-01	MEN'S RESIDENCE SOUTH	09/25/84
58	CHICAGO (WS), IL	537-02	NORTHWESTERN HOUSE	09/25/84
59	CHICAGO (WS), IL	537-03	GATEWAY FOUNDATION (LAKE VILLA)	09/25/84
60	CHICAGO (WS), IL	537-04	GATEWAY FOUNDATION (N. KEDZIE)	09/25/84
61	CINCINNATI, OH	539-02	TALBERT HOUSE (HALFWAY HOUSE FOR MEN)	09/06/84
62	CINCINNATI, OH	539-03	GOODWILL INDUSTRIES	09/06/84
63	CINCINNATI, OH	539-04	DROEGE HOUSE	09/06/84
64	CLEVELAND, OH	541-01	INTERVAL BROTHERHOOD HOME	09/13/84
65	CLEVELAND, OH	541-02	DONOFRIO HOME	09/13/84
66	CLEVELAND, OH	541-03	CHRISTOFF HOUSE	09/13/84
67	CLEVELAND, OH	541-05	WOODRUFF MANOR	09/13/84
68	CLEVELAND, OH	541-06	MATT TALBOT INN	09/13/84
69	CLEVELAND, OH	541-07	ORCA HOUSE	09/13/84
70	CLEVELAND, OH	541-08	NEWTON HOUSE	09/13/84
71	CLEVELAND, OH	541-09	TURNING POINT CENTER FOR CHANGE	09/13/84
72	CLEVELAND, OH	541-10	ROCCO ANTENNUCCI MEMORIAL ADULT RESIDENTIAL CENTER	09/24/84

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73	COATESVILLE, PA	542-01	SOUTHWOODS FACILITY (VITAE HOUSE)	09/10/84
74	COATESVILLE, PA	542-02	HARWOOD HALFWAY HOUSE	09/10/84
75	COLUMBIA, SC	544-01	LEXINGTON-RICHLAND ALCOHOL & DRUG ABUSE COUN HWH	09/04/84
76	COLUMBIA, SC	544-02	DAWN CENTER HALFWAY HOUSE	09/04/84
77	COLUMBIA, SC	544-03	LIBERTY HOUSE	09/04/84
78	COLUMBIA, SC	544-04	OUR PLACE	09/26/84
79	DALLAS, TX	549-01	VOLUNTEERS OF AMERICA COMMUNITY RESIDENTIAL CENTER	09/12/84
80	DALLAS, TX	549-03	AMERICAN INDIAN CENTER COUNCIL HOUSE	09/12/84
81	DENVER, CO	554-02	WILLIAMS STREET CENTER	09/06/84
82	DENVER, CO	554-03	SOBRIETY HOUSE, INC.	09/06/84
83	DES MOINES, IA	555-01	BURR WOOD CENTER	09/04/84
84	FAYETTEVILLE, AR	564-01	HARBOR HOUSE, INC.	10/16/84
85	FAYETTEVILLE, AR	564-02	DECISION POINT (CAUDLE)	10/16/84
86	FAYETTEVILLE, AR	564-03	DECISION POINT (LINDA)	10/16/84
87	FORT HARRISON, MT	436-02	BOYD ANDREW SERVICE CENTER (E. 9TH)	09/06/84
88	FORT HOWARD, MD	566-01	FRIENDSHIP HOUSE	09/10/84
89	FORT HOWARD, MD	566-02	GALE HOUSE	09/10/84
90	FORT LYON, CO	567-01	CROSSROADS HOUSE	09/13/84
91	FORT LYON, CO	567-02	SUN RISE INC., HOME	09/13/84
92	FORT MEADE, SD	568-01	FRIENDSHIP HOUSE, INC.	09/18/84
93	FORT MEADE, SD	568-02	GLORY HOUSE	09/18/84
94	FORT MEADE, SD	568-03	HOMESTEAD HALFWAY HOUSE	09/18/84
95	FORT MEADE, SD	568-04	SHERIDAN HALFWAY HOUSE	09/27/84
96	FORT MEADE, SD	568-05	THE ARCH HALFWAY HOUSE	09/18/84

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97	FORT MEADE, SD	568-06	MITCHELL ALCOHOL AND DRUG CENTER	09/18/84
98	FORT MEADE, SD	568-07	NEW DAWN	12/27/84
99	FRESNO, CA	570-01	PINE MANOR RECOVERY HOME	09/12/84
100	FRESNO, CA	570-03	HALFWAY HOUSES OF FRESNO (NORTH PLEASANT)	09/12/84
101	FRESNO, CA	570-04	ALPHA HALL RECOVERY HOME	09/12/84
102	FRESNO, CA	570-05	PORTERVILLE ALCOHOL ABUSE RECOVERY HOME	09/12/84
103	FRESNO, CA	570-06	TURTLE LODGE	09/12/84
104	FRESNO, CA	570-08	HALFWAY HOUSES OF FRESNO, INC (K. B. HOUSE)	09/12/84
105	GAINESVILLE, FL	573-01	ALCOTHON HOUSE, INC.	09/13/84
106	GAINESVILLE, FL	573-02	NORTH FLORIDA MENTAL HEALTH CENTER, INC.	09/19/84
107	HAMPTON, VA	590-01	FLYNN CHRISTIAN FELLOWSHIP HOUSE OF PORTSMOUTH, INC	08/31/84
108	HAMPTON, VA	590-02	SERENITY HOUSE	08/31/84
109	HINES, IL	578-01	NORTHWESTERN HOUSE	09/25/84
110	HINES, IL	578-02	OPPORTUNITY HOUSE	09/25/84
111	HINES, IL	578-03	MEN'S RESIDENCE SOUTH	09/25/84
112	HINES, IL	578-04	ELGIN RESIDENCE HALFWAY HOUSE	09/25/84
113	HINES, IL	578-05	GATEWAY FOUNDATION (LAKE VILLA)	10/16/84
114	HINES, IL	578-06	GATEWAY FOUNDATION (N. KEDZIE)	10/16/84
115	HOT SPRINGS, SD	579-01	HOMESTEAD HALFWAY HOUSE	09/06/84
116	HOT SPRINGS, SD	579-02	FRIENDSHIP HOUSE, INC.	09/06/84
117	HOT SPRINGS, SD	579-03	GLORY HOUSE	09/06/84
118	HOT SPRINGS, SD	579-04	RETAP	09/06/84
119	HOT SPRINGS, SD	579-05	THE ARCH HALFWAY HOUSE	09/06/84
120	HOT SPRINGS, SD	579-06	MITCHELL ALCOHOL AND DRUG CENTER	09/06/84

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121	HOT SPRINGS, SD	579-07	SHERIDAN HALFWAY HOUSE	09/27/84
122	HOUSTON, TX	580-02	OLDHAM RANCH	09/06/84
123	INDIANAPOLIS, IN	583-01	HARBOR LIGHT CENTER	09/04/84
124	JACKSON, MS	586-01	LEXINGTON HOUSE	09/13/84
125	JACKSON, MS	586-02	NEW HOPE THREE-QUARTER HOUSE	09/13/84
126	JACKSON, MS	586-04	NEW HORIZON HOUSE (RIVER OAKS APTS.)	09/13/84
127	KNOXVILLE, IA	592-01	SCARF HALFWAY HOUSE	09/11/84
128	KNOXVILLE, IA	592-03	VOSS RECOVERY HOME	09/11/84
129	KNOXVILLE, IA	592-04	KING'S HALFWAY HOUSE	09/11/84
130	KNOXVILLE, IA	592-05	GREEN ACRES MEN'S RESIDENCE	09/11/84
131	KNOXVILLE, IA	592-06	AREA SUBSTANCE ABUSE COUNCIL RESIDENTIAL FACILITY	09/11/84
132	KNOXVILLE, IA	592-07	CHEMICAL DEPENDENCY SERVICES OF NORTH IOWA, INC.	09/11/84
133	KNOXVILLE, IA	592-08	NORTH CENTRAL ALCOHOLISM RESEARCH FOUNDATION, INC.	09/11/84
134	KNOXVILLE, IA	592-09	SIOUXLAND COUNCIL ON ALCOHOLISM AND DRUG ABUSE	09/11/84
135	LAKE CITY, FL	594-01	NORTH FLORIDA MENTAL HEALTH CENTER, INC.	09/06/84
136	LEAVENWORTH, KS	686-01	SHARE HOUSE	09/11/84
137	LEAVENWORTH, KS	686-02	CEDAR HOUSE	09/11/84
138	LEAVENWORTH, KS	686-04	SHIELD OF SERVICE DETOX AND REINTEGRATION CNTR	09/11/84
139	LEXINGTON, KY	596-02	KESSLER HALFWAY HOUSE	09/19/84
140	LINCOLN, NE	597-01	HOUSE OF HOPE OF NEBRASKA, INC. (EUCLID)	09/19/84
141	LINCOLN, NE	597-02	HOUSE OF HOPE OF NEBRASKA, INC. (N STREET)	09/19/84
142	LINCOLN, NE	597-03	HOUSE OF HOPE OF NEBRASKA, INC. (S. 16TH)	09/19/84
143	LINCOLN, NE	597-05	HOMESTEAD HALFWAY HOUSE	09/19/84
144	LINCOLN, NE	597-06	RETAP HALFWAY HOUSE	09/19/84

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OBS	STATION	VACO ID	CONTRACT FACILITY	VACO APPROVAL
145	LINCOLN, NE	597-07	THE LINK, INC.	09/19/84
146	LINCOLN, NE	597-08	FRIENDSHIP HOUSE, INC.	09/19/84
147	LITTLE ROCK, AR	598-01	SALVATION ARMY ADULT REHABILITATION CENTER	09/19/84
148	LITTLE ROCK, AR	598-02	WILBUR D. MILLS ALCOHOLISM TREATMENT CENTER	09/19/84
149	LOMA LINDA, CA	605-01	HOW HOUSE	09/11/84
150	LOMA LINDA, CA	605-02	NEW HOUSE	09/11/84
151	LOMA LINDA, CA	605-03	LOST HEADS RANCH	09/11/84
152	LOMA LINDA, CA	605-04	HARRIS HOUSE (VARP)	09/11/84
153	LOMA LINDA, CA	605-05	MY FAMILY, INC.	09/11/84
154	LONG BEACH, CA	600-01	SOUTH COAST COUNSELING (EAST WILSON)	09/11/84
155	LONG BEACH, CA	600-02	SOUTH COAST COUNSELING (PLUMMER)	09/11/84
156	LONG BEACH, CA	600-03	SOUTH COAST COUNSELING (YORKTOWN)	09/11/84
157	LONG BEACH, CA	600-04	MEN'S 12TH STEP HOUSE	09/11/84
158	LOS ANGELES (B), CA	530-01	CLARE FOUNDATION	09/12/84
159	LOS ANGELES (B), CA	530-02	BISHOP GOODEN RECOVERY HOME	09/12/84
160	LOS ANGELES (B), CA	530-06	EAST LOS ANGELES TASK FORCE RECOVERY HOME	09/12/84
161	LOS ANGELES (B), CA	530-07	CASA DE LAS AMIGAS	09/12/84
162	LOS ANGELES (B), CA	530-08	BEACON HOUSE RECOVERY HOME	09/12/84
163	LOS ANGELES (B), CA	530-09	JAMAA RECOVERY HOME	09/12/84
164	LOS ANGELES (B), CA	530-10	ST. LUKE'S BOARD AND CARE	09/12/84
165	LOS ANGELES (B), CA	530-11	WESTSIDE COMMUNITY CARE CENTER	09/12/84
166	LOS ANGELES (B), CA	530-12	FUNCTIONAL LIVING CENTERS, INC.	09/12/84
167	LOS ANGELES (B), CA	530-13	CRI-HELP, INC.	09/12/84
168	LOS ANGELES (B), CA	530-14	IMPACT HOUSE	09/12/84

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169	LYONS, NJ	604-01	HALFWAY HOUSE OF LEHIGH VALLEY	09/10/84
170	MANCHESTER, NH	608-01	TIRRELL HALFWAY HOUSE	09/06/84
171	MARION, IN	610-01	THE WASHINGTON HOUSE	09/12/84
172	MARION, IN	610-02	LIFE HOUSE	09/12/84
173	MARION, IN	610-03	SALVATION ARMY HARBOR LIGHT CENTER	09/19/84
174	MARTINEZ, CA	612-01	DIABLO VALLEY RANCH	09/12/84
175	MARTINEZ, CA	612-02	SUNRISE HOUSE	09/12/84
176	MARTINEZ, CA	612-03	AMERICAN INDIAN SUBSTANCE ABUSE PROGRAM	09/12/84
177	MARTINEZ, CA	612-04	OUR FAMILY	09/12/84
178	MARTINEZ, CA	612-05	PATHWAYS I	09/12/84
179	MARTINEZ, CA	612-06	PATHWAYS II	09/12/84
180	MARTINEZ, CA	612-08	SOUTH PLACER RECOVERY HOME	09/12/84
181	MARTINEZ, CA	612-10	CARNALES UNIDOS REFORMANDO ADICTOS (CURA, INC.)	09/12/84
182	MARTINEZ, CA	612-12	MEXICAN AMERICAN ALCOHOLISM PROGRAM	09/12/84
183	MARTINEZ, CA	612-13	THE NEW BRIDGE FOUNDATION, INC.	09/12/84
184	MARTINEZ, CA	612-14	VETERANS HOME OF YOUNTVILLE	09/12/84
185	MARTINEZ, CA	612-15	EMPIRE HOTEL ALCOHOL RECOVERY CENTER	09/12/84
186	MARTINEZ, CA	612-17	TAHOE SIERRA COUNCIL	09/12/84
187	MARTINEZ, CA	612-18	PROGRESS HOUSE	09/12/84
188	MARTINEZ, CA	612-19	GATEWAY FOUNDATION, INC.	09/12/84
189	MARTINEZ, CA	612-20	SACRAMENTO RECOVERY HOUSE, INC.	09/12/84
190	MARTINEZ, CA	612-22	THE FORT BRAGG PILOT HOUSE	09/12/84
191	MARTINEZ, CA	612-23	VOSE RECOVERY HOUSE	09/12/84
192	MARTINEZ, CA	612-24	EAST COUNTY COMMUNITY RESIDENTIAL ALCOHOL SERVICE	09/12/84

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OBS	STATION	VACO ID	CONTRACT FACILITY	VACO APPROVAL
193	MARTINEZ, CA	612-23	FREDERICK OZANAM HOUSE	09/12/84
194	MARTINSBURG, WV	613-01	GALE HOUSE	09/19/84
195	MARTINSBURG, WV	613-02	THE WELLS HOUSE	09/19/84
196	MEMPHIS, TN	614-01	HARBOR HOUSE, INC.	09/06/84
197	MEMPHIS, TN	614-02	LAUDERDALE COUNTY NURSING HOME	01/08/85
198	MIAMI, FL	546-01	VILLAGE SOUTH, INC.	09/13/84
199	MIAMI, FL	546-02	BETHESDA MANOR	09/13/84
200	MONTROSE, NY	620-01	CLOVE MANOR	09/11/84
201	MONTROSE, NY	620-02	NEW LIFE MANOR	09/11/84
202	MOUNTAIN HOME, TN	621-01	MIDWAY REHABILITATION CENTER	09/06/84
203	MOUNTAIN HOME, TN	621-02	THE GREENHOUSE	09/06/84
204	MUSKOGEE, OK	623-01	HARBOR HOUSE OF MUSKOGEE, INC.	09/06/84
205	NEW ORLEANS, LA	629-01	BRIDGE HOUSE	09/13/84
206	NEW ORLEANS, LA	629-02	NEW MAY CENTER	09/13/84
207	OKLAHOMA CITY, OK	635-01	BRIDGE HOUSE	09/04/84
208	OKLAHOMA CITY, OK	635-02	ALPHA II	09/04/84
209	OKLAHOMA CITY, OK	635-03	HARBOR HOUSE OF MUSKOGEE, INC.	09/27/84
210	PHILADELPHIA, PA	642-01	DIAGNOSTIC AND REHABILITATION CENTER	01/29/85
211	PHOENIX, AZ	644-01	GUIDE POST	09/18/84
212	PHOENIX, AZ	644-02	PELMS HOUSE, INC.	09/18/84
213	PHOENIX, AZ	644-03	HARBOR LIGHT CENTER	09/18/84
214	PITTSBURGH (HD), PA	645-01	SALVATION ARMY HARBOR LIGHT CENTER	09/10/84
215	PITTSBURGH (HD), PA	645-02	SERENITY FARMS	09/10/84
216	PORTLAND/VANCOUVER, OR	648-01	JOHN OWEN RECOVERY HOUSE	09/06/84

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217	PORTLAND/VANCOUVER, OR	648-02	TAMARC, INC.	09/19/84
218	PRESCOTT, AZ	649-01	GUIDE POST	09/18/84
219	PROVIDENCE, RI	650-01	ROBERT J. WILSON HOUSE	09/06/84
220	PROVIDENCE, RI	650-02	TRI-HAB HOUSE, INC.	09/06/84
221	PROVIDENCE, RI	650-03	HELLDE HOUSE	09/18/84
222	RENO, NV	654-01	TRANSITION HOUSE	09/18/84
223	RENO, NV	654-02	AMERICAN INDIAN SUBSTANCE ABUSE PROGRAM	09/19/84
224	RENO, NV	654-03	PATHWAYS I	09/19/84
225	RENO, NV	654-04	PATHWAYS II	09/19/84
226	RENO, NV	654-05	SOUTH PLACER RECOVERY HOME	09/19/84
227	RENO, NV	654-06	TAHOE SIERRA COUNCIL	09/19/84
228	RENO, NV	654-07	SACRAMENTO RECOVERY HOUSE, INC.	09/19/84
229	RENO, NV	654-08	PROGRESS HOUSE	09/19/84
230	RENO, NV	654-09	EMPIRE HOTEL ALCOHOL RECOVERY CENTER	09/19/84
231	RENO, NV	654-10	MEXICAN AMERICAN ALCOHOLISM PROGRAM	09/19/84
232	ROSEBURG, OR	653-01	CARLTON HOUSE	09/12/84
233	ROSEBURG, OR	653-02	STEPPING STONES (KCAD)	09/12/84
234	ROSEBURG, OR	653-03	ROGUE RECOVERY HOUSE	09/12/84
235	ROSEBURG, OR	653-04	CARES (RECOVERY HOUSE I)	09/12/84
236	ROSEBURG, OR	653-05	SOUTH COAST RECOVERY CENTER	09/12/84
237	ROSEBURG, OR	653-06	THE CROSSROADS (ADAPT)	09/12/84
238	ROSEBURG, OR	653-07	PONDEROSA CENTER	09/12/84
239	SALEM, VA	658-01	MULTI-LODGE	09/18/84
240	SALT LAKE CITY, UT	660-01	PROGRESS HOUSE	09/13/84

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241	SALT LAKE CITY, UT	660-02	ALCOHOLIC TREATMENT CENTER	09/13/84
242	SAN ANTONIO, TX	671-01	ALCOHOLIC REHABILITATION CENTER	09/12/84
243	SAN ANTONIO, TX	671-02	CASA DEL SOL ALCOHOLIC HALFWAY HOUSE	09/12/84
244	SAN ANTONIO, TX	671-03	GOLDSMITH HOUSE	09/12/84
245	SAN DIEGO, CA	664-01	PATHFINDER, INC.	09/12/84
246	SAN DIEGO, CA	664-02	SOUTH BAY PIONEERS	09/12/84
247	SAN DIEGO, CA	664-03	TRADITIONS	09/12/84
248	SAN DIEGO, CA	664-04	HEARTLAND HOUSE	09/12/84
249	SAN DIEGO, CA	664-05	STEPPING STONES	09/12/84
250	SAN DIEGO, CA	664-06	CROSSROADS FOUNDATION	09/12/84
251	SAN DIEGO, CA	664-07	FELLOWSHIP CENTER	09/12/84
252	SAN DIEGO, CA	664-08	INDIAN GROWTH CENTER (FREEDOM RANCH)	09/12/84
253	SAN DIEGO, CA	664-09	SOBRIETY HOUSE	09/12/84
254	SAN DIEGO, CA	664-10	THE WAY BACK	09/12/84
255	SEATTLE, WA	663-01	PIONEER HUMAN SERVICE	09/19/84
256	SHERIDAN, WY	666-01	SHERIDAN HALFWAY HOUSE	09/13/84
257	SHERIDAN, WY	666-04	BOYD ANDREW SERVICE CENTER (EAST 9TH.)	09/13/84
258	SHERIDAN, WY	666-05	CHEYENNE HALFWAY HOUSE	09/25/84
259	SHERIDAN, WY	666-07	WILLIAMS STREET CENTER	09/25/84
260	SPOKANE, WA	668-01	DELANEY HOUSE	09/04/84
261	SPOKANE, WA	668-02	SHAW HOUSE	09/04/84
262	SPOKANE, WA	668-03	WESTBROOK HOUSE	09/04/84
263	ST. CLOUD, MN	656-01	FOCUS [illegible] HALFWAY HOUSE	09/13/84
264	ST. CLOUD, MN	656-02	CHAIN O' LAKES HALFWAY HOUSE	09/13/84

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265	ST. CLOUD, MN	656-03	HOUSE OF HOPE HALFWAY HOUSE (MANKATO)	09/13/84
266	ST. CLOUD, MN	656-05	KINNIC FALLS HALFWAY HOUSE	09/13/84
267	ST. CLOUD, MN	656-06	NU-WAY HALFWAY HOUSE	09/13/84
268	ST. CLOUD, MN	656-07	THE ARCH HALFWAY HOUSE	09/13/84
269	ST. CLOUD, MN	656-08	DUNN COUNTY ASSOC ON ALCOHOL & OTHER DRUG ABUSE	09/13/84
270	ST. CLOUD, MN	656-09	FREEDOM HOUSE	01/29/85
271	ST. LOUIS, MO	657-01	HARRIS HOUSE FOUNDATION	11/19/84
272	TAMPA, FL	673-01	ALCOHOL COMMUNITY TREATMENT SERVICES (NEBRASKA)	09/13/84
273	TAMPA, FL	673-02	ALCOHOL COMMUNITY TREATMENT SERVICES (BUFFALO)	09/13/84
274	TEMPLE, TX	674-01	CENTEX ALCOHOLIC REHABILITATION CENTER	09/12/84
275	TEMPLE, TX	674-02	STRATFORD PASO HOUSE	09/12/84
276	TOGUS, ME	402-01	BANGOR HALFWAY HOUSE	09/11/84
277	TOGUS, ME	402-02	SERENITY HOUSE	09/11/84
278	TOGUS, ME	402-03	FELLOWSHIP HOUSE	09/11/84
279	TOGUS, ME	402-04	MILESTONE FOUNDATION	10/30/84
280	TOMAH, WI	676-01	PINECREST CENTER	09/12/84
281	TOMAH, WI	676-02	DUNN COUNTY ASSOC ON ALCOHOL & OTHER DRUG ABUSE	09/12/84
282	TOMAH, WI	676-04	KOINONIA HALFWAY HOUSE	09/12/84
283	TOMAH, WI	676-05	PATHFINDER HOUSE	09/12/84
284	TOMAH, WI	676-06	HOPE HAVEN HALFWAY HOUSE	09/12/84
285	TOMAH, WI	676-07	REBOS HOUSE OF WISCONSIN, INC.	09/12/84
286	TOMAH, WI	676-08	KINNIC FALLS HALFWAY HOUSE	09/12/84
287	TOMAH, WI	676-09	HALF WAY HOME PROGRAM	09/12/84
288	TOMAH, WI	676-10	LAAR HOUSE	09/12/84

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289	TOMAH, WI	676-11	ALDA HOUSE	09/12/84
290	TOMAH, WI	676-12	HOUSE OF HOPE HALFWAY HOUSE	09/25/84
291	TOMAH, WI	676-13	HOLY FAMILY RETREAT HOME	10/16/84
292	WACO, TX	685-01	FREEMAN HOUSE	09/12/84
293	WASHINGTON, D.C.	688-02	HOPE VILLAGE HALFWAY HOUSE	09/10/84
294	WHITE CITY, OR	692-01	CARES (RECOVERY HOUSE I)	09/12/84
295	WHITE CITY, OR	692-02	ROGUE RECOVERY HOUSE	09/12/84
296	WHITE CITY, OR	692-03	STEPPING STONES (KCAD)	09/12/84
297	WHITE CITY, OR	692-04	PIONEER HUMAN SERVICE	09/19/84
298	WHITE CITY, OR	692-05	CARLTON HOUSE	09/12/84
299	WHITE CITY, OR	692-06	JOHN OWEN RECOVERY HOUSE	09/19/84
300	WHITE RIVER JUNCTION, VT	405-01	GRACE HOUSE, INC.	09/11/84
301	WHITE RIVER JUNCTION, VT	405-02	SERENITY HOUSE	09/11/84
302	WOOD, WI	695-01	HOLY FAMILY RETREAT HOME	09/13/84
303	WOOD, WI	695-02	SALVATION ARMY EMERGENCY LODGE	09/13/84

Question 52A. Page 31 and 32 of the "Admininstrator's Digest" of the report on "Caring for the older veteran" (July 1984) state a goal "to develop and implement appropriate linkages among VA and non-VA services targeted at meeting the needs of older individuals".

Are resources included in the fiscal year 1986 budget request for the designation of 172 FTEE to be distributed at each VA Medical Center to serve as VA-community specialists?

Answer 52A. The 1986 budget does not include any additional resources for full-time liaison positions to coordinate the health services of the VA and community programs. The Agency will be utilizing the Information and Referral Program to apply towards the objectives cited in the Aging Report. This ongoing program is already located at each medical center.

Question 52B. What resources (dollars) would be required to provide each VA medical center with such a specialist?

Answer 52B. The establishment of a program with a full-time coordinator at each of the 172 medical centers would cost approximately $7.8 million.

Question 53. The final report of the MAXIMUS Corporation Study of the possible effects of imposing "user fees" on veterans applying for VA health care was due in November 1984. What is the status of the study?

Answer 53. The VA, in 1983, was directed by OMB to undertake a study of "user fees" which was to be carried out within the context of a broader study aimed at developing a demographic profile of veteran beneficiaries. MAXIMUS, Inc., was awarded the contract to develop the beneficiary profile, to study the VA's Beneficiary Travel Program, and to conduct a review of the literature on the effects of "user fees." In June 1984, MAXIMUS presented a study questionnaire to OMB for approval. The VA was told to delete all questions relating to user fees and to confine the study of "user fees" to a review of the literature. Hence, the VA discontinued the survey aspects for a study of the possible effects of imposing user fees on veterans applying for VA health care.

Question 54A. Booz, Allen has completed the first two phases of its assessment of the VA's planning process for major facilities construction.

What has Booz Allen identified thus far as the major strengths and weaknesses of the VA's planning process for the construction of medical facilities?

Answer 54A. Weaknesses - Deficiencies in the Planning of Medical System Projects

- o Lack of explicit priorities for meeting construction needs. The problem begins in the MEDIPP process and continues through construction program planning
- o Lack of fully effective facility construction planning

Weaknesses - Deficiencies in Planning Information Cause Weaknesses in the Process Control System

- o Standards for defining project scope
- o Standards for projecting staffing requirements
- o Standards for determining project space requirements

Weaknesses - Process Requirements Limit the Effectiveness of the Current Organization to Carry Out the HCF Construction Process

- o The organizations for carrying out the HCF Construction Process do not efficiently and effectively meet current process requirements

Strengths - The Current Process Embodies Characteristics that Provide a Good Foundation for Improvement

- o Even with the weaknesses in the construction program and project planning, the process generally results in high-quality projects that are executed within established cost targets
- o Another strength according to Booz, Allen were our comprehensive standards for defining the construction quality required for VA facilities
- o A final strength is the design review procedure for identifying and correcting design errors and omissions

Question 54B. What are your views on Booz Allen's findings?

Answer 54B. Their findings are sound and accurate. They have data to back-up all of their conclusions.

- Our Steering Committee, which is made up of the Chief Medical Director; Associate Deputy Administrator for Logistics; Director, Office of Construction; and others have fully agreed with the contractor's findings. We fully agree that our major problems exist with front-end planning which then causes problems which have a rippling effect through the entire process.

Question 54C. What do you believe are the major strengths and weaknesses of the VA's construction planning process?

Answer 54C. I agree with the contractor's findings. Our greatest weakness is that VA Medical Center staff need more meaningful input in the construction planning process. They are the ultimate users and need greater involvement in front-end planning. I think our major strength is that our system has been delivering quality health care facilities despite our problems in front-end planning. We truly have a solid foundation for polishing and improving our system.

Question 55. What methodology is used to determine the bed size of new and replacement VA hospitals and what specific factors are taken into account?

Answer 55. The bed size of new and replacement VA hospitals is determined through the MEDIPP process largely on the basis of the VA hospital bed sizing model. This model takes into account historical discharge rates, changes in the size and age structure of the veteran population, VA length of stay, community length of stay standards, optimal occupancy rates, and appropriate locations of treatment (hospital vs. non-hospital).

Question 55A. Is the demand for "discretionary" versus "nondiscretionary" visits (i.e., visits for the treatment of service-connected disabilities, others) considered in this process? If not, why not?

Answer 55A. The demand for "discretionary" versus "nondiscretionary" workload is not considered in this process because it was not negotiated into the model which was mandated by Congress and jointly approved by VA and GAO.

Question 55B. What would be the impact on the size, number and location of VA hospitals were the VA to plan to build only to meet the "nondiscretionary" workload?

Answer 55B. If the VA were to plan to build only to meet the "nondiscretionary" workload, the size of facilities would decline to a degree dictated by the definition of "nondiscretionary" workload. Since all medical centers treat some "nondiscretionary" workload, this planning criterion would not affect the number and placement of facilities.

Question 55C. Would this result in any changes in the size, number and order of priorities listed in the FY 1985-1989 Five Year Medical Facility Construction Needs Assessment?

Answer 55C. Yes, for those projects for which size is a factor, such a planning policy would affect the number of projects that would be required as well as the size and priority. Because the impact of the policy would vary from facility to facility, it would be difficult to make meaningful statements regarding the overall impact in the absence of comparative "nondiscretionary" workload statistics at all facilities.

Question 55D. What, if any, impact would there be on (1) the quality of care provided in VA hospitals and (2) the future of the VA health care system if the VA planned only to meet the "nondiscretionary" workload?

Answer 55D. Meeting "nondiscretionary" workload only might require, due to economy of scale considerations, a reduction of the comprehensive treatment capabilities now provided by the VA. This could result in the eventual deterioration of the quality of patient care which could be rendered.

Question 55E. What, if any, efforts are underway to re-examine the VA bedsizing model?

Answer 55E. The VA continually investigates, revises, and enhances the VA hospital sizing model under the guidance of an advisory group of non-VA health planning experts, including representatives from GAO.

Question 56A. According to the General Accounting Office, in fiscal year 1983, 35 of 160 VA medical centers had occupancy rates of 75 percent or less; 13 of them were 70 percent or less. For fiscal year 1984, 44 of 159 VA medical centers had occupancy rates of 75 percent or less; 20 of these were 70 percent or less. Every medical center in Medical District 16 was under 75 percent. The medical center in Miles City, Montana, had a 49.4 percent occupancy rate. The occupancy rate for surgical bed sections was even lower: in fiscal year 1983, 64 of 135 surgical bed units had occupancy rates of 75 percent or less.

Is this analysis correct? If not, why not?

Answer 56A. Yes

Question 56B. What do these data indicate about the efficiency of the VA health care delivery system?

Answer 56B. The above data reflect the impact of increased efficiency resulting from emphasizing outpatient programs and other alternatives to hospital care. Lower occupancy rates naturally result from the use of these options. Also, the migration of the veteran population to the "sunbelt" from the "frostbelt" sometimes results in increased demand pressure in the "sunbelt" and decreased demand pressure in the "frostbelt."

Question 56C. What occupancy rates are assumed in the bed sizing model for medical and surgical beds and for psychiatric beds? Are these reasonable indicators of the performance of VA hospitals? If not, what occupancy rates should VA hospitals be expected to achieve?

Answer 56C. The occupancy rates which the VA bed sizing model assumes are as follows: medical beds, 85 percent; surgical beds, 85 percent; and psychiatric beds, 90 percent. These are reasonable standards to conform to and the future system occupancy rates are expected to approach these levels.

Question 56D. Occupancy rates can be increased by increasing a facility's workload or by decreasing its bed supply. Which of these two alternatives is preferable and would be more likely to increase the rates of the facilities with rates currently under 75 percent? What effect would each alternative have on veterans' access to needed health care, the quality of that care and the operating budget of that facility?

Answer 56D. The preferred approach and effect depend upon local factors at each VA medical center. The accessibility to health care and the high quality of that care will continue under either alternative. However, to maintain higher occupancy rates under the workload expansion scenario, the facilities will need increased operating funds.

Question 56E. What impact will the proposed reduction in FTEE have on VA occupancy rates?

Answer 56E. The 1986 FTEE levels basically will have no direct impact on occupancy rates. Occupancy rates are the function of two things. First, there is the average bed level. Second, is the average daily census which is also determined by average employment (FTEE). In 1986, a slight increase in occupancy rates are projected. This is basically due to a reduction in the average hospital and domiciliary bed levels. The hospital bed reduction reflects further implementation of privacy standards and a conversion of hospital beds to longer term care modalities (nursing and intermediate care beds are increasing). Domiciliary beds are being reduced to eliminate beds which do not meet program standards or needs. The 1986 budget projects the following increases in VA bed occupancy rates: the VA hospitals project a 1986 occupancy rate of 80.2 percent, a slight increase from the 1984 level of 79.6 percent; VA nursing estimates an occupancy rate of 94.5 percent, an increase of 1.1 percent over the 1984 level of 93.4 percent and a 1.8 percent increase over the projected 1985 estimate of 92.7 percent; and a domiciliary 1986 occupancy rate of 80.9 percent which reflects a 1.8 percent increase over the actual 1984 level of 79.1 percent.

Question 57A. In its attachment, "Senate Committee on Veterans' Affairs Views on Approval of FY 1985 VA Replacement/Modernization Construction Projects", to the Committee's resolution approving certain major medical construction projects for fiscal year 1985, the Committee listed certain hospital bedsizing data for each of the proposed construction projects. (A copy is attached for your convenience).

Is this analysis correct? If not, why not?

Answer 57A. **Yes. It is a correct application of the assumptions underlying the Senate "bed reallocation model."**

Question 57B. **If so, how do you justify building a new facility in Houston when only 8.4% of the inpatient population at the current Houston VA Medical Center is service-connected, while, at the same time the overall VA inpatient population is 30% service-connected, especially in light of the finite amount of available construction resources?**

Answer 57B. **The project size is based on the use of the VA bed sizing model, which was mandated by Congress and jointly accepted by VA and GAO. This model does not include explicit consideration of the service-connected (SC) patient load. In addition, the 8.4% SC figure for Houston refers to the treatment of SC veterans for SC conditions. The 30% systemwide figure refers to SC veterans treated for all conditions, both SC and non-SC. The corresponding figure for Houston is 20.8% for FY 1983, however this figure rose to 22.1% in FY 1984.**

Question 58A. **What factors are taken into account to determine "appropriate market share" in the VA's planning for hospital and nursing home construction?**

What market share is reflected by the workload projections listed in the fiscal year 1986 budget request?

Answer 58A. **Only planning for construction of nursing homes takes into consideration market share figures. "Market share" in hospital construction is only implicit in that historical data over a number of years are used.**

The VA nursing home care program provides nursing care as well as opportunities for social, diversional, recreational, and spiritual activities for veterans. A full range of medical and rehabilitative services are available at the host medical center.

The VA, however, can only provide such services to a portion of the total need, known as VA "market share," because of such factors as eligibility limitations, medical insurance coverage, personal choice of veterans, existence of alternatives to nursing care, and the availability of State nursing home beds.

Since factors governing market shares vary widely, resulting projections of Medical District market shares will vary widely. In order to minimize extreme variations a range for market share of 12%-16% is established as the ideal planning range. Each planning cycle, Medical Districts are to re-evaluate their market share choice based on the factors listed above.

The census figures presented in the 1986 budget represent approximately 15% of the total veteran nursing home demand which is within the planning range of 12% to 16%.

Question 58B. What impact will the proposed means test have on the VA's market share.

Answer 58B. We expect that approximately 38,000 veterans under age 65 and 9,700 veterans 65 years of age and older will be determined able to pay for the cost of needed health care. Our market share of nursing home care should remain stable since those veterans who utilize Medicare or other health insurance coverage for nursing home care will turn to the VA when their insurance coverage is exhausted. Those veterans in need of other medical care who are determined to be able to pay for such care, will be replaced by other applicants who will meet the means test.

Question 59. The fiscal year 1985-1989 Five-Year Medical Facility Construction Needs Assessment "List of 10" stated that the three medical centers judged most in need of construction, replacement or modernization were those facilities in Houston, Texas; Allen Park, Michigan; and Mountain Home, Tennessee. What accounts for the disparity between this list and the list of facilities for which funding was requested in the VA fiscal year 1986 budget?

Answer 59. The project for the Replacement/Modernization of VAMC Allen Park, Michigan, was not included in the VA fiscal year 1986 budget request due to the need to issue a supplemental draft to the Environmental Impact Statement to address a split-facility concept. Following the completion of this requirement, a Record of Decision as to the preferred alternative for this Replacement/Modernization project will be made. The requirements for inclusion of this project into the budget process will then be finalized.

Question 60. The "age factor" was part of the justification, as described at the House Subcommittee hearing on February 7, 1985, in response to Congressman Edgar's questions, for the Houston facility to be ranked first in the order of medical facility construction projects for FY 1986. The existing Houston facility has components which date back to the 1930's and 1950's, as compared to the Philadelphia Hospital, ranked third, which dates back only to 1951.

A. Most of the buildings of the Augusta, Georgia, Uptown Division were constructed in the 1920's. How do you justify according high priority to other facilities not as old as Augusta's?

B. Given that only two major medical facility projects were requested this year, why were two acute care facilities funded rather than one acute care and one long-term care facility?

C. In light of the priority accorded the Augusta hospital, what, if anything, may we conclude about the priority accorded in the construction planning process to the needs of long-term psychiatric care patients vis-a-vis medical-surgical patients?

Answer 60. A. Age of the physical plant is but one of the many factors considered in determining the priority of the replacement/modernization projects. Other factors, such as projected changes in demand and medical technology, space and functional deficiencies are considered along with the age factor. As compared to the Augusta projects, the deficiencies, in the aggregate, of other replacement/modernization projects accorded these projects a higher priority than Augusta.

B. As a health care system, the DM&S and the VA are dedicated to the provision of health care through missions of both acute care and long-term care facilities. As such, the long-term/acute care status of a facility has little bearing on the outcome of the priority setting process. As explained previously, many factors are considered in determining construction priorities. The fact that other facilities were deemed to be of a higher priority than the Augusta project was not related to Augusta's long-term care mission.

C. All other long-term care facilities for which construction projects are prepared will compete on an equal basis with acute care facilities. The priority determination factors other than mission will be equally applied with regard to each project, with the most needy facilities receiving the highest priority.

Question 61. Why were the Houston and Philadelphia nursing home projects included on the list of replacement and modernization projects and not on the list of nursing home projects?

Answer 61. In each case, the nursing home care unit is a part of the major replacement and modernization project.

Question 62. The Fiscal Year 1984-1988 Five Year Medical Facility Construction Needs Assessment listed the Marion, IN, and Tucson, AZ, nursing homes as the top priorities for fiscal year 1986 nursing home construction projects. The Albuquerque, NM, and Amarillo, TX, nursing homes were cited as the top priorities for fiscal year 1987 nursing home projects. However, the fiscal year 1986 budget requests funds for the Tucson and Amarillo projects.

A. How did you determine these relative priorities? What factors do you consider? How do you measure them?

B. What accounts for the change in the order of priorities?

C. Where do the Marion and Albuquerque projects fall now on the list of priorities and when do you expect to seek funding for them?

Answer 62. The major projects contained in the "Five Year Needs Assessment" are listed alphabetically, not in priority sequence. Although listed alphabetically in the "Needs Assessment" the VA does prioritize the projects in the nursing home care category. The prioritization method has been based on the percentage of "Met Need" in the Districts in which the Medical Centers are located. The Districts with the lowest precentage of "Met Need" (actual NHC beds vs. projected NHC beds) received the highest priority. The priorities for the FY 1984-FY 1988 "Needs Assessment" were established using pre-1980 census data. The subsequent "Needs Assessment" used the 1983 MEDIPP plans which, in turn, were based on the 1980 census data. This data established a shift of the veteran population towards the sun belt areas, thereby increasing our projected need of nursing home care beds in these areas, and changing the order of priorities which had been established in the FY 1984-FY 1988 "Needs Assessment". The net result was that Tucson and Amarillo, located where our greatest percentage of need (NHCU beds) occurred, became our top priorities in FY 1986.

The priority methodology for nursing home care units for FY 1987 has been further defined to include not only the District unmet need, but also functional and physical deficiencies in existing NHCUs. At this time, the Marion, IN, and Albuquerque, NM NHCU projects are being considered for the FY 1987 NHC program.

Question 63. What, if any, modifications to the construction planning process are necessary to better link the Needs Assessment and the budget request?

Answer 63. The Medical Facility Construction Needs Assessment documents the long-range construction needs of DM&S. Although the document attempts to present a balanced approach over a five-year period, it is not a budget document. The Needs Assessment identifies requirements for major construction at VA Medical Centers and as such is the data base of projects from which budget selections are made. It is recognized that constrained budgets will not support planning figures of the magnitude presented in the Needs Assessment.

Question 64. Did any projects which were listed in the needs assessment and planned for this year's budget, but which are not included in the budget request, receive design fund monies for final drawings?

Answer 64. Projects listed in the needs assessment planned for this year's budget, but not included in the budget request, did not receive design fund monies for final drawings.

The following projects are designated to receive funds from the FY 1985 Design Fund.

Tomah, Wisconsin	Modernize Buildings 403 and 404
Wood, Wisconsin	Renovate Building 43 for Domiciliary
Long Beach, California	Upgrade Secondary Electrical Distribution
Chicago (WS), Illinois	Renovation of Buildings 11A and 11B. Phase II
Poplar Bluff, Missouri	Electrical Distribution System Improvements

Jackson, Mississippi	Install Sprinkler System
Knoxville, Iowa	Fire and Safety Improvements
Cleveland (Wade Park), Ohio	Fire and Safety Improvements
Cleveland (Brecksville), Ohio	Fire and Safety Improvements
Big Spring, Texas	Renovate Surgery
Chicago (WS), Illinois	Fire and Safety and Patient Privacy Improvements
Hampton, Virginia	Electrical Systems Modernization
Hines, Illinois	180-Bed Psychiatric Replacement Facility
San Diego, California	Non-Structural Seismic Corrections
Tucson, Arizona	120-Bed Nursing Home Care Unit
Durham, North Carolina	Parking Garage
Florida National Cemetery	Develop 13,000 Gravesites and Construct Administration Building
St. Louis (Jefferson Barracks), Missouri	Seismic Corrections
Temple, Texas	408-Bed Replacement Domiciliary
Coatesville, Pennsylvania	New Kitchen and Dining Hall
Togus, Maine	Clinical Improvements, Building 200
Syracuse, New York	Parking Garage
Lyons, New Jersey	Renovate Buildings 7 and 57

Question 65A. In the fiscal year 1986 budget request, $160 million from the working reserve fund will be used to pay for some of the major construction projects.

What is the current balance in the working reserve fund and what do you expect the balance to be on October 1, 1985?

Answer 65A. The current balance of the working reserve fund as shown in the FY 1986 budget is $36,770,000. Several reprogrammings approved since the budget or others in process reduce the balance to $28,931,960. We cannot predict what balance will be available on October 1, 1985.

Question 65B. For each project to which working reserve funds were reprogrammed during fiscal years 1984 and 1985 (to date) please provide the following information:

- Funding approved by the Veterans' Affairs Committees and appropriated by the Congress.
- Funding reprogrammed from working reserve fund.
- Date on which Appropriations Committees were notified of the reprogramming.

Answer 65B. The following list shows each project which received reprogrammed funds from the working reserve during FY 1984 and FY 1985 to date. Also, shown is the amount available on the project prior to the reprogramming, the amount of the reprogramming and the date Congress was notified by the VA.

Project	Available Funds	Reprogrammed Funds	Date
Cincinnati, Ohio Clinical Expansion and Relocation/2 Additional Elevators and Correction of Fire and Safety	$11,005,000	$570,000	01/20/84
Coatesville, Pennsylvania Air Conditioning, Ward Renovation and Energy Conservation	16,743,000	3,796,000	12/12/84
Houston, Texas Correct Electrical Deficiencies	1,975,000	523,800	02/04/85
Long Beach, California Research Addition	8,650,000	600,000	08/31/84
Los Angeles, California Outpatient Clinic and Land Acquisition	3,000,000	4,000,000	05/21/84
Martinsburg, West Virginia Demolition, Site Work and Utilities	1,584,000	860,000	11/02/84
Pittsburgh, Pennsylvania Ambulatory and Clinical Addition	24,500,000	4,200,000	01/13/84
Salt Lake City, Utah Clinical Ambulatory Care Addition - Remodel Building 1 Ground Floor for Pharmacy, MAS and Other Functions	21,968,000	1,100,000	02/03/84
Tucson, Arizona Clinical Addition	13,382,000	520,000	11/20/84
West Palm Beach, Florida APF Funds for New Hospital	25,000,000	3,000,000	02/22/84

Question 66. Are property appraisals routinely and regularly conducted in order to compile current data on the value of VA properties? Would such information be useful in determining the current value of VA land and facilities to assist in the review of planned major facility construction projects?

Answer 66. The Department of Medicine and Surgery does not routinely and regularly secure appraisals for the purpose of compiling current data on the value of its facilities. For the most part DM&S facilities are unique to the mission of the agency and would not be considered for disposal. Where no disposal action is anticipated, the routine collection of appraisal data would be an extremely costly excercise with little benefit.

We would, however, support the procurement of appraisals on selected properties when the nature of planned construction is not site restrictive and the opportunity to put such property to better use exists.

Question 67. Are efforts underway to test, on a pilot program basis at selected medical facilities, a new formula to determine the number of parking spaces for patients, employees, and visitors at VA medical centers?

A. What are the results of this pilot program?

B. What impact would the new formula have on the number and costs of parking spaces required at each medical facility?

Answers 67A & B. The VA has developed a new methodology for determining parking demand at VA facilities based on the results of a recently completed consultant study. The new formulas have been incorporated into a Draft Space Planning Criteria which is currently being circulated through the Agency for review and comments. The proposed methodology will be used as a guideline for determining the number of parking spaces needed for employees, outpatients, and visitors at VA facilites, and will utilize such critical variables as ridesharing, geographical location, affiliation status, availability of public transportation, and the differences in parking demand experienced by Regional Offices, psychiatric, general medical, and outpatient facilities. The new formulas have been tested at eight VA facilites and have generated results which are within ten percent of the measured peak parking demand.

The new methodology is significantly more site specific than the existing parking criteria. Therefore, the new formulas have indicated a need for more spaces in some instances, and a need for fewer spaces in other cases. There has been no analysis to date of the overall cost impact of the proposed methodology.

Question 68A.

The Grace Commission, in an analysis of government data processing -- encompassing hardware, software, systems compatibility, intra- and inter-agency data communications, user accessability, and data verification, among other criteria -- reported that Veterans' Administration computers cannot verify the accuracy of benefits payments, and that this inability contributes to a payments error rate exceeding $500 million per year.

In current DVB Strategic Information Systems Plan 1987-1991, the DVB has a stated goal (#2) to "Improve and expand the application of automated technology to delivery of benefits."

Given these two general statements, please be more specific with regard to the DVB information strategy and comment on VA ADP efforts to accurately track and verify payments in an effort to reduce this error rate, if, in fact, the error rate given is accurate. If the error rate mentioned in the Grace Commission report is not accurate, please provide the error rate the VA projects over one year, and the dollar amount this error rate incurs.

Answer 68A. **The "two general statements" refer to essentially different topics. Error detection is the primary thrust of the former. The latter intends to address delivery of services, especially benefits, to improve the VA's overall ability to communicate with veterans and other beneficiaries and deliver payments more quickly to them, an important aspect of the VA mission.**

In its "Report on the Veterans Administration," the Grace Commission stated, "The extent of errors present in the Department of Veterans Benefit (DVB) payment system is not known." This statement, appearing in Part II, on page 21. is closely followed by a statement estimating that $500 million in accounts receivable will be created in each of the following two years.

The Grace Commission report proposed two remedies to assess the extent of errors in claims submitted and control against subsequent unknown status changes resulting in erroneous bases for claims. In focusing on the area of erroneous informaton submitted with beneficiaries' claims, the report recommended a study of beneficiaries' reporting errors and recommended increased efforts to verify information after award of benefits through automated data exchanges and matching programs.

We are working to upgrade our on-going data exchange with the Social Security Administration and increase the number of exchanges with other Federal agencies. We have commenced an exchange with OPM (1984) to verify annuity payments for former Federal employees and their survivors. We are nearing completion of formal agreements with the Department of Labor and the Railroad Retirement Board to verify payments of Black Lung benefits and former employees' and survivors' annuity payments.

The DVB Information Systems Plan 1987-1991 recently developed is the Department's early integrated, strategic plan to improve benefits delivery to all eligible beneficiaries. The plan addresses ADP needs department-wide to accomplish several goals.

Certainly aspects of the plan, particularly those related to major equipment acquisition and systems design and integration, can facilitate error detection and prevention measures. The plan however, does not focus on such initiatives. Such initiatives will be accommodated without need to be a major part of the plan and are already being developed based on existing capabilities.

From the data processing standpoint, we are not aware of any program logic errors which are contributing to the payments error. ADP programs are verified and audited to correctly reflect specifications developed by DVB program specialists. Coordination between program and data processing designers is open and correct.

Question 68B. Please comment on the Veterans' Administration's connection with the Department of Defense "TRIMIS" program, and the database sharing and/or development — specifically addressing MUMPS — that may be in progress. Does the VA plan to develop a common-language database with DoD for the purposes of data sharing and communication? If not, why not? Please comment on the feasibility of developing a common agency data protocol that would allow for the transfer of patient/personnel records from active-duty DoD files to VA files at such point in time when an individual enters the VA care/benefits system.

Answer 68B. The Veterans Administration and Department of Defense are working on three activities involving TRIMIS. The Loma Linda VAMC and March Air Force Base have developed a sharing agreement under which the VA would provide technical assistance for testing and evaluation of VA DHCP (MUMPS and VA File Manager based) software at the March AFB hospital. The TRIMIS procurement strategy for its Composite Health Care System will include a benchmark test and evaluation between at least two vendors, one of which will use and adapt VA software for the TRIMIS environment.

The VA and TRIMIS program office have held several meetings on the subject of data sharing, and plan to meet on a periodic basis. Progress has been made in identifying minimal requirements for patient transfer supporting the VA's role as primary contingency backup to the DoD health care system, with an initial focus on patient transfer during emergency mobilization or disaster situations. Future meetings will address requirements for peacetime transfer of patients and what data should be transferred in an automated form. The VA is developing comprehensive narrative definitions of the elements in the DHCP applications, focusing first on elements in the Initial Core modules. Core modules, the anchor for the rest of DHCP, include patient identifying demographic and admission/discharge/transfer information that would be involved in patient transfer. Publication of the DM&S Information Systems Data Dictionary in FY 1985 will provide valuable input for inter-agency data exchange protocols. DM&S definitions can be matched against TRIMIS definitions. Data transfer would be facilitated by using the same software in the VA/TRIMIS for common functions and, implicit with that, standard definitions and for nomenclature data elements.

Question 68C. Please submit a complete inventory of all VA ADP hardware by location. In addition, list all current systems languages in use and VA communications protocol i.e., how batched material is transmitted from station to station, baud rates commonly used, types of modems, public or private telecommunications systems used for transmission, etc.

Answer 68C. Per your request, a copy of the current ADP Inventory is being produced. The full report (approximately 1500 pages) will be transmitted to your office by March 7.

The VA has a wide variety of data processing system languages in use. These languages range from very low level languages such as Assembler Language Coding to very high level "application generator" languages. In the VA medical community, a strong emphasis is being placed on use of MUMPS for data processing, while the rest of the VA emphasizes the use of COBOL. Exceptions to the use of COBOL exist:

for historical reasons (e.g. AUTOCODER is in use because it predated the availability of COBOL); because of the sharing of software among agencies (e.g., FORTRAN is a common language for certain packages used by the VA but developed elsewhere); for reasons of expediency when long-term maintenance by other than the end-user is not anticipated (e.g., specialized statistical analysis software such as SAS and SPSS, and generalized report generators such as DYL 260 and AZ-7 are in wide use); and because of requirements for data structure compatibility (e.g., user database query languages are peculiar to a database management system).

Attached is a copy of a draft standard which delineates the communications protocols that will be used within the VA.

Veterans Administration
Washington, D.C. 20420

Circular 00-84-

Date

Standard Protocols for Accessing VA Wide Area Data Communications Networks

1. Purpose. The purpose of this Circular is to provide guidance for VA organizations which need the capabilities and the services of VA wide area data communications networks and to ensure that, by following the disciplines outlined in this Circular, users and application systems will be able to communicate successfully with predetermined nodes in VA wide area networks.

2. Scope. The policy and procedures outlined in this Circular encompass all existing wide area data communications networks and all wide area data communications networks to be implemented; the totality of which will comprise the Veterans Administration's integrated data communications networks. The integrated data communications networks will become functional through an evolutionary process as these disciplines and procedures are applied and as they are further enhanced, thereby keeping the VA telecommunications networks current with the state-of-the-art in Automatic Data Processing. Equipment (hardware and related software) in the following categories are explicitly subject to this Circular:

local area networks (LANS) requiring access to wide area networks, automatic private branch exchanges (PBX), data terminals configured using telecommunications facilities (as opposed to direct connected terminals), terminal concentrators, data multiplexers, communications front-end processors and micro, mini and large computers with integrated communications interface architecture requiring access to wide area networks. All hardware and related software not identified in the foregoing equipment list that uses a wide area data communications network, either through a direct connection or through dial-up facilities, are implicitly subject to this Circular.

3. Background. The Veterans Administration's use of data communications networks in the past has employed specialized, dedicated facilities for different requirements. For example, the Department of Veterans Benefits' Target network is a collection of dedicated lines, hardware and software providing a specialized service to veterans relative to the Compensation, Pension and Education System. Another dedicated facility provides several application systems and a large volume of timesharing users support through the shared use of dedicated lines between ODM&T field facilities.

Additionally, the capability to transmit and receive both data and administrative traffic between VA facilities has been employed since February 1966 through the General Services Administration's Advanced Record System (ARS). The ARS was conceptualized by GSA, implemented in 1964 through multiple contracts and administered by GSA through December 1983.

The VA is now in the process of moving from using numerous specialized networks, which have highly constrained interface capabilities, to integrated data communications networks. The process will be evolutionary requiring a number of years to achieve full functionality of inter-network communications. The first significant move toward an integrated data communications network came on January 1, 1984 when the responsibility for the ARS was transferred to the VA. The ARS has been renamed the VA Data Transmission System (VADATS). VADATS includes a value added packet network resulting from the specialized hardware and software provided by a contractor. The packet network technology makes it possible to move toward our goal of a multi-mode, integrated data network sooner than previously planned. The current VADATS supports only the message switched, store-and-forward mode of operation. The VA is committed to the planned expansion of the existing VADATS packet network (See Attachment A) to support multiple modes of operation. The additional modes of operation will be:

a. Terminal interface for interactive mode utilizing asynchronous teletype (TTY) or emulated 3270 bisynchronous or 3270 bisynchronous protocols.

b. Terminal interface for remote batch (remote job entry, file transfer) mode utilizing 3780 bisynchronous protocol.

c. Host computer interface for interactive mode utilizing asynchronous TTY, bisynchronous or X.25 protocols.

d. Host computer interface for remote batch mode utilizing 3780 bisynchronous or X.25 protocols.

e. Host-to-host file transfer mode utilizing asynchronous TTY, bisynchronous or X.25 protocols.

f. Electronic mail mode utilizing asynchronous TTY, bisynchronous or X.25 protocols.

g. Gateways to other wide area networks or LANS utilizing asynchronous TTY, bisynchronous or X.25 protocols.

The enhanced VADATS supporting the modes and protocols listed above is planned to be installed and operational at approximately 250 VA stations by the end of December 1986.

4. Policy Effective January 1, 1985 VA managers have the responsibility of ensuring that organizational elements within their control:

a. maximize support for the design and development of applications that utilize the standard protocols identified in this Circular. Compliance with the standards contained herein will expedite the introduction of applications onto the networks and will avoid unnecessary costs. Plans and requirements that do not involve the immediate use of, or represent potential interface with, the Agency's wide area data communications networks are exempt from this Circular.

b. recognize the Director, ODM&T, as manager of the VA's wide area data communications networks. This function is necessary to ensure the operational integrity of the networks and to ensure uninterrupted service to all VA users. Exceptions to these standards, e.g., accepting new protocols into the Agency's telecommunications process, must be approved by the ADA/IRM.

c. must provide the Director, ODM&T communications workload characteristics for each application that is proposed to be connected to the network in order to ensure network capacity and operational integrity. To assure network compatibility for new types of equipment, all initial equipment acquisitions interfacing with the VA networks must be subjected to a live test demonstration to ensure proper interface.

5. Definitions. Attachment B is a glossary of words or terms used in this Circular. The definitions given are complete to the degree necessary to understand the word or term in the context presented in this Circular and are not intended to represent an "unabridged" definition.

6. Responsibilities.

a. The Associate Deputy Administrator for Information Resources Management (ADA/IRM) has the responsibility for:

(1) reviewing this policy and guidance annually and updating it as needed.

(2) approving or disapproving, as is prudent, the acceptance of additional protocols for use in the VA's wide area data communications networks.

b. The Director, Office of Data Management and Telecommunications (ODM&T) has the responsibility for providing and managing wide area networks. Specifically, ODM&T will be responsible for:

(1) providing technical oversight for all data communications equipments for applications that plan to utilize a VA wide area network. The degree of technical oversight and depth of review will vary primarily based on the protocol interface selected.

(2) providing technical assistance to users and potential users in interfacing with the network protocol interfaces.

(3) disseminating to all VA managers changes in scope or capabilities of the network protocol interfaces.

(4) maintaining a file of equipment certified for use in VA wide area data communications networks.

(5) authenticating users prior to their gaining access to VA wide area data communications networks.

c. Department Heads, Associate Deputy Administrators, and Staff Office Directors will be responsible for compliance with this Circular within their organizations in all areas relating to data and/or administrative traffic transmitted or received via telecommunications facilities. Specifically, they will be responsible for:

(1) ensuring that all wide area data communications requirements be planned and coordinated with ODM&T to maximize orderly inplementations.

(2) restricting communications protocols to those identified in Paragraph 7 of this Circular.

(3) limiting equipment acquisitions requiring access to wide area data communications networks to equipment that utilizes the standard network protocols.

(4) complying with the disciplines and procedures outlined in this Circular.

7. Standard Network Protocols. The primary vehicle for integration of data communications within the Veterans Administration will be VADATS. This network is going through an evolutionary process that will support the standard network protocols identified in this paragraph. VADATS will also provide gateways to other networks, internal and/or external to the Veterans Administration's integrated networks. Any device or application system requiring access to VADATS must utilize one or a combination of the following standard protocols:

a. Asynchronous TTY Terminal and Host Interfaces. The Enhanced VADATS will support the asynchronous TTY (start-stop) protocol for asynchronous terminals and asynchronous host computer port interfaces. It may be assumed that any device that supports this widely used, vendor independent, de facto standard will interface to the Enhanced VADATS network. Any true asychronous TTY device can be supported by this network interface. Any host computer utilizing the asynchronous interface must provide X-ON, X-OFF flow control capabilities. Coordination with the Director, ODM&T is required for new applications utilizing this protocol.

b. Emulated 3270 Bisynchronous on Asynchronous Terminals. The Enhanced VADATS will support emulated 3270 bisynchronous functionality for a limited set of asynchronous terminals. This emulation will provide 3270 bisynchronous functionality. A list of usable terminals will be provided on request. Coordination with ODM&T is required for implementation of this protocol interface.

c. 3270 Bisynchronous Terminal and Host Computer Interfaces. The Enhanced VADATS network will support the industry de facto 3270 bisynchronous protocol for original source terminal devices, 3270 compatible terminal devices and the 3270 bisynchronous host interface. This protocol has been implemented in a standard fashion both by the original manufacturers and manufacturers of compatible devices. VADATS certification is required as a part of any acquisition for 3270 bisynchronous devices. Coordination with the Director, ODM&T for specific configuration information is required. It is encouraged that a live pilot demonstration including both terminals and host computers via a VADATS connection be required in any acquisition process.

d. 3780 Bisynchronous Terminal and Host Computer Interfaces. The Enhanced VADATS network will support the 3780 bisynchronous protocol interface for remote batch terminals and host computer port interfaces utilized for file transfer. Due to the large number of variations in implementation of this protocol, the interfacing of 3780 bisynchronous equipment to the Enhanced VADATS network will be handled on a case-by-case basis. Close coordination with the Director, ODM&T will be necessary. Any organization intending to utilize this protocol on the network may be required to provide a device for the purpose of testing and certification. A list of devices that are operational over the 3780 bisynchronous interface will be maintained. A determination will be made by the Director, ODM&T as to whether or not a physical device for certification will be required.

e. SDLC Interface. The Enhanced VADATS is planning to support the Synchronous Data Link Control (SDLC) protocol interface.

This protocol is currently in beta test by the VADATS contractor. A live pilot demonstration showing end-to-end communications is required before implementation of any nation-wide implementation of an application utilizing SDLC.

f. X.25 Interface. The Enhanced VADATS will support the Federal Standard 1041 (FIPS Publication 100) X.25 interface to packet-switched data communications networks. An extract from FIPS Publication 100 is included as Attachment C. A copy of the complete standard can be obtained from the Director, ODM&T. All acquisitions for large mainframe computers and local area networks requiring access to wide area networks must have an X.25 interface. It is strongly encouraged that mini-computer and PBX acquisitions consider including an X.25 interface as a mandatory requirement. Coordination during the acquisition process is required. A live pilot demonstration showing end-to-end communications is required before approval may be given of any nation-wide implementation for a new application utilizing the X.25 interface.

8. Rescission. This circular is rescinded on December 31, 1985.

By direction of the Administrator:

EVERETT ALVAREZ, JR.
Deputy Administrator

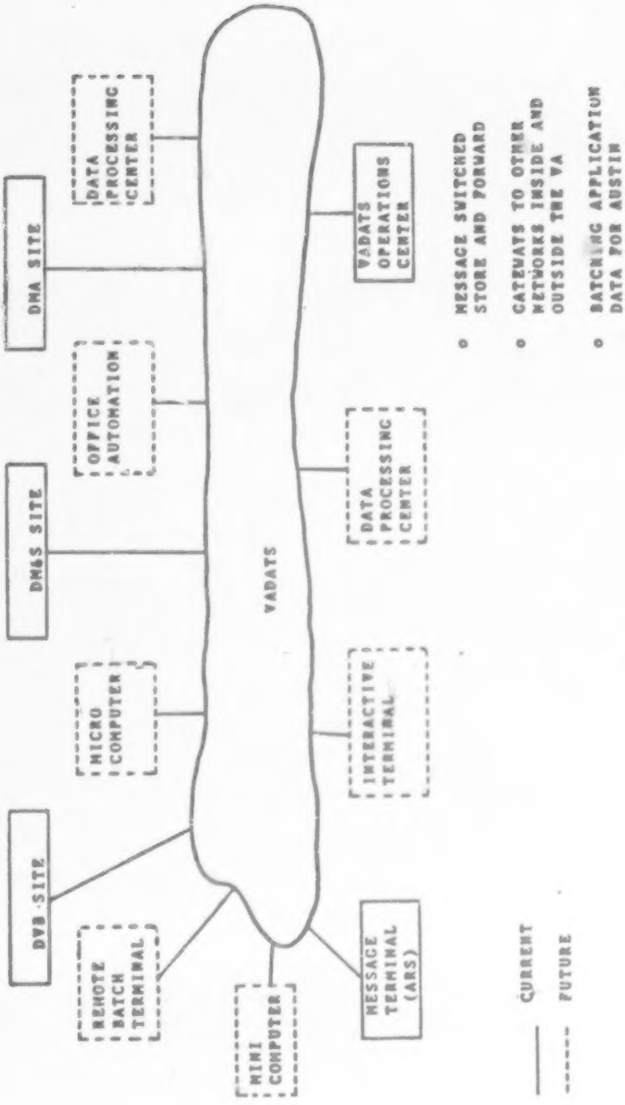
Attachments

Distribution:

FD

Circular 00-84
ATTACHMENT A

FUTURE DATA COMMUNICATIONS UTILITY


DVB SITE
DM&S SITE
DMA SITE
MICRO COMPUTER
OFFICE AUTOMATION
DATA PROCESSING CENTER
REMOTE BATCH TERMINAL
MINI COMPUTER
MESSAGE TERMINAL (ARS)
INTERACTIVE TERMINAL
DATA PROCESSING CENTER
VADATS OPERATIONS CENTER
VADATS
CURRENT
FUTURE

- MESSAGE SWITCHED STORE AND FORWARD
- GATEWAYS TO OTHER NETWORKS INSIDE AND OUTSIDE THE VA
- BATCHING APPLICATION DATA FOR AUSTIN

Asynchronous TTY: A communications line control technique where each transmitted character has self contained beginning and ending indications, so individual characters can be transmitted at arbitrary times.

Bisynchronous: A Binary synchronous communications (BSC) family of half duplex protocols that uses transmission control characters to control the data transferring over a communications line. The ANSI 3.28 control character set is utilized.

CCITT: The International Telegraph and Telephone Consultative Committee. An Agency of the International Telecommunication Union (ITU). Its responsibilities are global coordination for telephone and data communication systems.

Communication Front-end Processors: A specialized computer processor generally used with a large mainframe computer that interfaces the computer to communications facilities and remote users.

Concentrator (Terminal): A device that combines a multiple of low-speed communication links onto one high-speed communication link.

Data Multiplexer (mux): A device that combines information (data) from a number of input sources to a single output source.

HDLC: High-Level Data Link control is a generic name for a number of bit-oriented data link control procedures and standards. Each of the standards utilizes the same frame structure and is full duplex. Control commands are transmitted via bit patterns rather than control characters.

HOST: An intelligent processor or device connected to a network that satisfies the needs of remote users.

LAPB: (Link Access Procedure - Balanced Mode) A subset of High Level Data Link Control (HDLC), and functions within the parameters of X.25 based networks. Within LAPB parameters, the Data Terminal Equipment (DTE) and the Data Communication Equipment (DCE) interface to operate in "balanced mode."

Local Area Network (LAN): A communications network which connects a number of communications links within a limited and well defined area, normally, a single building or a group of buildings.

Node (computer): A point of a network where various links come together; generally containing a switching element (computer) used to direct traffic.

Private Branch Exchange (PBX): A computer system design to automatically route voice and/or data over telephone lines internally or to a public network.

Protocol: A set of rules and procedures that permits the orderly exchange of information within and across a network.

Remote Batch: A process of remotely inputting defined units of data records (files) onto a central computer system.

SDLC: Synchronous Data Link Control is a subset of HDLC.

Wide Area Network (WAN): A communications network which connects a group of communication links and/or local area networks over a dispersed geographical area; normally, intercity or interstate.

X.25: A three level protocol (physical, link and network/packet) developed by the CCITT which is an international standard for data sharing and file transfer (packet switching) that defines the message structure required by data terminal equipment to interface with a CCITT defined public packet network.

3270 bisynchronous: A bisynchronous polling protocol used in data communication which transmits data in a full screen format.

3780 bisynchronous: A protocol used to communicate collective transactions (batch, full files) in data communication.

Circular CC-84
ATTACHMENT C

Name of Standard: Interface Between Data Terminal Equipment (DTE) and Data Circuit-Terminating Equipment (DCE) for Operation with Packet-switched Data Communications Networks.

Category of Standard: Hardware, Data Transmission. Explanation: Federal automated data processing equipment, services, and telecommunication equipment using public packet-switched data communications networks (PSDCN) based on the family of CCITT Recommendations derived from X.1 and X.2 shall employ the interface and protocols specified in this joint standard. In addition, designers of these internally operated and maintained Federal networks employing packet-switched technology should consider the use of this interface as appropriate. The joint standard provides:

- A family of physical interfaces, from which a particular interface may be selected; and
- A single data link layer control procedure; and
- Packet level procedures for virtual calls and permanent virtual circuits, and an optional datagram operation. The mandatory interface attributes of this joint standard are summarized as follows:

PHYSICAL LEVEL

Transmission rates:	2.4, 4.8, 9.6Kbits/s
Interface:	one or more of the following: RS-232-C, X.21, RS-449

LINK LEVEL:

Procedure:	LAPB
Parameter K:	7
Smallest N1:	164 Octets

PACKET LEVEL:

Services:	Virtual call and permanent virtual circuit
Packet types:	All basic plus Diagnostic packets. Packet Reject shall not be used.

User data field length:	Octet-aligned
Packet sequence Numbering:	Modulo 8
D bit procedure:	Supported by all DCEs; DTE need not employ the D bit when sending to the DCE, but no DTE shall reject incoming packet with the D bit set to 1 or 0 as having this bit in error unless it is known by receiver that the sender has no D bit capability.
X.25 diagnostic codes:	Use standard codes whenever they apply; non-std codes may be used for events not listed in X.25 within a period of 24 months after the effective date of this standard.
Fast Select:	DCEs shall implement fast select; DTE need not employ fast select when sending to DCE, but all DTEs with higher level functionality which allows response to fast select must be able to accept incoming fast select packet.
Interrupt packet:	Receipt of a DTE interrupt packet before a previous DTE interrupt packet has been confirmed is an error condition.
Duplicated facility codes:	The last appearing facility code should be treated by the DTE as if it were the only appearance of that code.
Non-zero cause field of restart request packet:	Discarded
Restart request too long in state r1:	Discarded

This joint standard is intended to enhance interoperability by specifying certain subsets and other constraints on Federal use of CCITT Recommendation X.25. The Government's intent in employing this joint standard is to reduce the cost of acquiring and using Federal automated data processing equipment, services, and telecommunication equipment with PSDCN. The joint standard is also intended to reduce the cost of acquiring and using Government-owned or leased PSDCN. These goals will be achieved by:

- Increasing the available alternative sources of supply;

- Increasing the reutilization of Government resources; and,

- Assuring the required interoperability.

Approving Authority: Secretary of Commerce (Federal Information Processing Standards). Administrator, General Services Administration (Federal Standards).

Maintenance Agency: The National Bureau of Standards and the Office of the Manager, National Communications System will jointly maintain the standard coordinating as necessary with the General Services Administration (GSA).

(End of Extract)

Question 68D. Please comment on the possibility/feasibility of developing a data transmission network based on satellite transponders, using current government uplink/downlink sites, microwave technology and VAMC/Regional Office-positioned direct satellite broadcasting receiving dishes.

Answer 68D. The VA has not eliminated any available technology in providing data transmission networking for the VA. The current and planned technology is continually being monitored to determine the most cost effective data transmission media for the VA. The VA currently does not utilize satellite transponders. Many of the VA facilities are located in low density areas where there would not be the option of utilizing current government uplink/downlink sites. Future procurement for replacement of the existing VA Data Transmission System will be via the competitive process which allows all technologies to compete.

Question 69A. VA has a task force studying methods of improving the dual data flows that feed the case mix equation --the clinical data from the Patient Treatment File (PTF), and cost data from the RCS 14-4 Cost Allocation Reports. What specific problems has VA identified in the accuracy, reliability, consistency, comparability, and timeliness of the data in these two files? What specific actions is VA undertaking to (1) improve the accuracy, reliability, and timeliness of the data of the files, and (2) increase the comparability of the data from hospital to hospital?

Answer 69A. The data from the RCS 14-4 and the Patient Treatment File (PTF) have become more accurate, reliable and consistent during the past 1-1/2 years as a consequence of their being used to distribute medical center target allowances. At present there are no ways to ascertain the accuracy of all the data from the data systems used to create RCS 14-4. The data are as accurate as the reporting facilities can or will make them. The data themselves cannot be compared among facilities as they are absolute data, not relative data. It is envisioned that comparability measures will be developed to determine, to the extent possible, whether reported data are "within acceptable range or limits." The comparability of the PTF data is addressed often in terms of readmission rates, mortality rates, and so on, but not in a resource allocation context nor on a recurring basis by VA Central Office Staff. The accuracy of the PTF data has been studied a number of times and found to be similar to that of patient discharge abstract systems outside the VA. VA medical centers are comparable when weighted work units (relative measures) are generated for each medical center using the DRG case mix that combines cost data from the RCS 14-4 and clinical data from the PTF. The data for the PTF and the component systems for the RCS 14-4 are reported on a recurring basis with opportunities for correcting errors found at the Austin Data Processing Center or at the medical centers. For purposes of resource allocation, both these data bases are assumed to be "closed", and not subject to updating, near the end of the November following the end of a fiscal year. All medical centers have opportunities to provide accurate and complete data by the cutoff dates.

Question 69B. VA has 2 pilot projects underway to develop methodologies for linking VA's clinical, workload, and accounting data bases (e.g., the PTF, Centralized Accounting for Local Managment (CALM), and Automated Management Information System (AMIS) to determine per patient treatment costs.

What current impediments hinder the ability to develop per patient cost? For example:

1) allocating personnel costs to program areas in the hospital via the RCS 14-4 Cost Allocation Reports (e.g., to Neurology, Surgery, Radiology, etc.)

2) allocating costs now captured at the ward or service level to the patient level?

3) maintaining accurate, up-to-date clinical data on patients?

Answer 69B. Current impediments to developing per patient costs are as follows: (1) Current financial data are not collected at the patient level. Therefore, either global estimates have to be made at the bed service or program level and assumed to be applicable to groups of patients within those bed services or programs, or patient-specific financial systems have to be developed to capture those data for individual patients. Numerous such systems are in use in the private sector. The VA is examining the applicability of several of them. (2) Historically, the VA has had no need to know per patient costs other than per diem costs at the medical center level. The casemix resource allocation system allows the VA to estimate in the broadest sense the cost of treating patients at the bed service level. However, the estimates are not sensitive to the individual costs of multiple inputs to the treatment of individual patients (e.g., ancillary services costs, administrative costs, personnel costs, and so on). Without a complete overhaul of how the VA's cost and clinical data are collected, the estimates will continue to be insensitive to the variation in and the contribution of associated costs of multiple inputs to patient care.

Question 70. The CMR (asset tracking) system in VA is a centralized data base maintained by the Austin Data Processing Center. Individual hospitals cannot access this information. Replacement equipment needs, or the useful expected life of replacement medical equipment is thus not identified at the hospital level. Yet, the need for replacement equipment can become a major planning and budgeting issue, particularly in the sixth or seventh year of the life of a replacement hospital.

How does the VA determine both its immediate budgetary needs for replacement equipment (i.e., the coming fiscal year) and its long-term budgetary needs?

Answer 70. Central Office receives summary information about replacement equipment needs from the LOG 1 048 Report. It contains the current year (including prior year backlogs) plus five years. This forms the basis of the agency's replacement equipment needs. As new or replacement equipment is purchased and old equipment disposed of, the transactions are coded into the system by the field facility. At least annually, the responsible field official is provided a report (staffed through supply service) for review. This report provides an opportunity to extend the useful life where appropriate and update replacement costs.

Question 71.

When the Decentralized Hospital Computer Program (DHCP) is fully operational, it should provide an online, clinical record for each patient. Will and can this system be used to track treatment patterns and drug use among patients? For example, can it be used to track "prescription shopping" by VA outpatients at several closely situated VA hospitals or outpatient clinics? If not, why not?

Answer 71.

The DHCP systems at each medical center provide online availability to clinical information. Among other things, this does allow each medical center to track activities such as treatment patterns and drug use among patients.

We are also exploring alternatives for providing this same capability among medical centers located in geographical proximity to one another.

Our current plans are to pilot test this capability in districts 17 and 26. A workgroup has been formed consisting of representatives from the two districts and the Pharmacy Special Interest Users Group to identify the functional requirements associated with sharing pharmacy data among facilities. At the same time, the DHCP technical community is analyzing the associated communications requirements. Based on the findings of these groups, development and pilot test implementation schedules will be established during the third quarter of FY 1985.

Question 72.

VA has underway a number of simultaneous efforts to improve key management information and accounting systems, including the Patient Treatment File, the RCS-14-4 Cost Allocation Reports, and the Automated Management Information System (AMIS). It is not clear from the 1985-89 ADP Plan precisely what Management Information Goal(s) are driving these various efforts, or how they would be linked in a real time network that provides for both ready access via terminal, and manipulation of data in a variety of ways for management reports and analysis. In particular, how is VA not only addressing these problems, but coordinating the efforts between the Department of Medicine and Surgery and the rest of the VA?

Answer 72.

VA's key management information systems are aimed at enabling managers at all levels to make timely resource management and policy decisions in order to better serve eligible veterans. The Decentralized Medical Management System (DMMS) will integrate medical, financial, and administrative data within the medical center and will transmit summary data to central systems via the VADATS communications network. Ad hoc reporting, statistical and modeling facilities will be incorporated into DMMS. Plans for improvement of DM&S information systems will be detailed in a report to Congress due to be submitted this Spring. This report will be prepared in cooperation with the Office of Data Management and Telecommunications (ODM&T). Coordination between DM&S and the rest of VA also takes place in a variety of working groups and committees. DM&S has established liaisons with VA's Improved Management Information System (IMIS) Task Force and the Paid Redesign Group. Data dictionaries are also being developed to ensure the use of common definitions in all systems.

The development and testing of input transactions from DHCP computers to Outpatient File (OP) and to the Patient Treatment File (PTF) at the Austin DPC were begun in 1984. With the completion of testing and distribution of DHCP software in FY 1985, OP and PTF inputs will be routinely transmitted from medical centers to the Austin DPC. Finally, on-line access to DVB data will be provided, in time, to medical centers through the VA data transmission system (VADATS) and the Target network. ODM&T is currently working on the development of this capability.

Question 73A.

VA's 5-year ADP plan provides an estimation of DHCP life cycle cost that appears to exclude some cost elements that we believe should be included to present a more accurate representation of total system cost. For example, current estimates do not include all costs that may be incurred by individual VAMC sites to fully support and operate the DHCP system. In addition, the cost to support and operate the DHCP system modules that will be implemented beginning in FY 1985, and the cost for some support organizations (e.g., Special Interest Users Group) formed to assist system development and implementation are also not included.

What DHCP costs are incurred at individual VAMC's that are not reflected in the current DHCP life cycle cost estimated $294 million?

Answer 73A.

The computation of "life cycle costs" is a function of the number of years used as the systems life cycle. Some life cycle costs for DHCP were based on an eight year cycle and some were based on a ten year cycle. The standard for computing life cycle cost for DHCP is eight years. The $294 million ten year life cycle cost was developed at the request of the Congress in order to compare DHCP costs with the Integerated Hospital System (IHS) cost over a ten year period and included estimates for Enhanced DHCP. The current estimates through fiscal year 1990 (eight years) for Initial and Full CORE amount to $211,907,000. Some of the aspects of Initial and Full CORE implementation are an integral part of the day-to-day operations of the medical centers, therefore, it is not possible to identify the local costs directly associated with DHCP and those costs associated with regular hospital operations. All identifiable costs incurred at individual VAMC's in support of the DHCP are reflected in the current life cycle cost estimates.

Question 73B.

Has VA established a system to identify and track individual VAMC DHCP expenditures to provide for a full costing of DHCP? If data is available, provide the actual DHCP operating expenditures funded from individual site budgets for class I, II, III, IV and V VAMCS.

Answer 73B.

The VA has not established a system to specifically identify and track local VAMC expenditures associated with its DHCP. Data is not available on DHCP operating expenditures funded from individual site budgets because of the close intertwining of the Initial and Full CORE applications with the day-to-day operations of the medical centers. All known expenditures including equipment purchases, equipment maintenance, travel, operating supplies, site preparation, and site manager personnel are included in the current DHCP systems life cycle cost estimates.

Question 73C.

For future planning purposes, has VA surveyed VAMC's to determine the estimated annual site level cost to support DHCP? Provide an estimate of annual DHCP recurring site and operating costs for personnel, maintenance, supplies, and other recurring items for class I, II, III, IV and V VAMCS for FY 85 - FY 92.

Answer 73C.

VA has not surveyed VAMC's to determine the estimated annual site level cost to support DHCP. When fully implemented, DHCP will become an integral part of normal hospital operations. It would not be possible for the individual hospital's Fiscal Offices to identify and account for local site level DHCP costs, other local ADP costs, and those costs associated with normal hospital operations. The annual recurring operating costs for DHCP for class I through V VAMCs are linear from FY 85 through FY 92 for DHCP Initial and Full CORE and is estimated at $20.8 million per year.

Question 73D.

Has VA developed estimates of additional hardware, software, or personnel costs that may be incurred as a result of developing, installing, and implementing enhanced DHCP? If so, please provide the cost estimates. If not, when will efforts be initiated to begin studying the cost impact of this phase of DHCP?

Answer 73D.

Estimates for implementing Enhanced DHCP have not been fully developed at this time. Current plans call for the consolidation and integration of ADP initiatives previously referred to as Field Office Automation and Local Field Initiatives into the composition of Enhanced and Comprehensive DHCP. We are currently working to expand the scope of DHCP under the VA Modernization Plan. This plan will further develop the initial concept of Enhanced DHCP into the automation of primary clinical support services and certain management/administrative functions that cut across all hospital services. In order for each medical center to complete an integrated system, additional hardware and software will be required. The full implementation of DHCP requires integration of all functions in the hospitals and integration with the Agency systems used to manage cost accounting, personnel accounting, supply management and all aspects of management information relative to clinical care. This undertaking will likely require resources of the magnitude estimated for Initial and Full CORE (see question IV A. 5a). It is premature to provide specific estimates of the life cycle costs of this future development effort.

Question 73E.

Are there any costs incurred by the VDC's, the SIUG's and MIRMO that are not currently reflected in VA's DHCP life cycle cost estimate of $294 million? What are they?

Answer 73E.

All identifiable costs are reflected in the current DHCP life cycle cost estimates. It is not possible to account for all of the indirect overhead costs associated with the DHCP. Most of these indirect overhead costs are associated with the management and administration of the Program. The remainder is made up of small amounts of personnel time for travel and to attend meetings and are incurred throughout the entire VA health care delivery system.

Question 74A. OMB A-108 Privacy Act - requires that agencies report the safeguards on the privacy of records on new ADP systems. How is VA addressing the problem of maintaining controls over the privacy of veterans personal data in the Decentralized Hospital Computer System?

Answer 74A. A number of security features have been utilized in the implementation of the Decentralized Hospital Computer Program (DHCP) systems in the VA medical centers (VAMCs). These include:

- Site Preparation Guidelines were issued to all VAMCs which defined environmental and security features to be incorporated into the construction of the DHCP computer rooms.
- The DHCP system software uses access and verify codes to identify individual users to the system, menu management features to limit the functions an individual user may perform to those necessary to the performance of his/her job, and file access mechanisms which limit access to DHCP files and which define the types of access system users may have to these files. These software security features serve to limit access to the DHCP system to authorized users and to control the types of access these users may have to the system based upon the requirements of the individual position.
- Supported by guidance received from Central Office and the Verification and Develoment Centers, ADP security procedures have been developed and implemented by the ADP Site Managers at VAMCs.

In order to formalize the DM&S ADP security program, the DM&S ADP Security Policy and ADP Security Guidelines for the Medical Centers have been prepared for dissemination throughout DM&S. This policy and the guidelines address all aspects of, and the designation of responsibility for, ADP security within DM&S and provide the foundation for the development and/or evaluation of station-specific ADP security procedures.

Question 74B. OMB A-71, transmittal #1 states that agencies should perform a risk analysis of security vulnerabilities to minimize potential loss. Has VA performed an analysis of the security risks involved with DHCP computerization of patient data in the medical centers?

Answer 74B. During the inception of the Decentralized Hospital Computer Program (DHCP), a preliminary Risk Analysis was performed by the DHCP Task Force. Comprehensive information about specific hardware configurations and related costs and information about the operational impacts of system loss at individual medical facilities were not available at that time. Additional risk analyses of the DHCP will be based upon the guidance provided in the DM&S ADP Security Guidelines for the Medical Centers.

Question 75. Before veterans receive care in the VA medical centers, eligibility needs to be established. How does the Decentralized Hospital Computer Program establish eligibility at the medical centers for patient care?

Answer 75. The Decentralized Hospital Computer Program (DHCP) does not establish eligibility. The Registration application of DHCP includes a field that indicates if patient eligibility has been verified - i.e. whether or not a patients statements in the application, that imply eligibility for care, have been verified. The process of verification involves our confirmation of several elements from VA Regional Office records associated with patient eligibility such as character of discharge; receipt of pension or compensation, if compensation the service-connected disability and percentage; POW status; period of service etc. The Department is currently working with ODM&T, and DVB to establish a capability for on-line communication with DVB using the VADATS network. The goal of this effort is to provide an on-line inquiry into the Target System as well as an electronic transfer of information between medical centers and VA Regional Offices. It should be noted that in view of the complex nature of eligibility determination we do not anticipate that the eligibility determination will be automated; as this is a cognitive process. However, the ready access of information necessary to determine eligibility will improve the timeliness of these determinations. The kinds of communication between medical centers and regional offices which are being explored include admission notices, 21 day certifications, Compensation and Pension examination requests etc.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN SUPPLEMENTAL QUESTIONS SUBMITTED BY HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. In Section 1519(a) of Title 38, the law states that you shall carry out an ongoing program of activities to enhance the VA's ability to provide rehabilitation programs for veterans. One aspect of this requirement is research in the area of psychological, educational, employment, social, vocational, industrial and economic aspects of rehabilitating disabled veterans. What specifically has the Agency done to respond to this statutory requirement and where is the funding for such efforts reflected in the VA's budget request for FY 1986?

Answer 1. In May 1984 the VR&C Service contracted with Seminars for Personal Growth, Inc., Alexandria, VA, to develop materials which would increase the resources and potential for accomplishing the rehabilitation of disabled veterans. This produced a document entitled, "Your Job Search," an 80-page employment assistance guide for Chapter 31 participants and VR&C regional office staff. The use of this guide was presented at the VR&C Officer Workshop held in St. Louis, MO, in June of 1984.

Additionally, modest research initiatives using existing resources are represented by:

- Consultative participation with the SBA in the production of the booklet, "Businesses that Can Be Owned and Operated by Handicapped Veterans;"

- Part-time staff participation in a University of Florida study of roles and functions, of VA rehabilitation staff.

Funds for this initiative are included as normal operating expenses.

Question 2. Please provide an explanation of the difference between the state approving agencies' job of approving educational installation for Chapter 34 (GI Bill) and the new Chapter 30 (Peacetime GI Bill) program as compared to the vocational rehabilitation specialists who approve training for veterans who are training under Chapter 31 (Vocational Rehabilitation). It's my understanding that sometimes these approvals are made for the same schools and the same veterans. Would you tell me the history of this separation of functions and provide me with your views on the merits of continuing under this format?

Answer 2.

Statutory authority for the establishment of State Approving Agencies is contained in 38 U.S.C, Chapter 36, Subchapter I. One of the primary duties and responsibilities of the State Approving Agencies is to ascertain the qualifications of institutions and training establishments to offer instruction under 38 U.S.C., Chapters 30, 32, 34, and 35.

The current approach in providing rehabilitation services and assistance under Chapter 31 can be characterized as personal, comprehensive assistance to the population being served. Each service-disabled veteran who applies for rehabilitation benefits and is eligible for and entitled to vocational rehabilitation services, is provided an individual evaluation by a professional VA counseling psychologist. A veteran's eligibility and entitlement to rehabilitation services is determined by a counseling psychologist and, in concert with the veteran and a vocational rehabilitation specialist, it is decided how the veteran can best be provided rehabilitation assistance. Then the counseling psychologist, vocational rehabilitation specialist, and veteran develop a rehabilitation plan. This plan sets forth the overall rehabilitation goals, objectives, actions to be taken, evaluation criteria, and overall responsibilities. The plan is then carried out with the vocational rehabilitation specialist providing individualized assistance to the veteran throughout the program.

The vocational rehabilitation specialist is responsible for assuring that the facility selected to carry out the rehabilitation plan is prepared to meet the veteran's individual needs. The specific criteria used by the vocational rehabilitation specialist are contained in 38 CFR 21.290 through 21.299. Generally, a facility approved for veterans under Chapter 34 would be acceptable for service-disabled veterans training under Chapter 31. However, programs and facilities appropriately approved under Chapter 31 may not meet the requirements for approval under Chapter 34. We believe it is desirable to continue this separation of function in order to best serve the needs of both disabled and non-disabled veterans.

Question 3.

You have contracted to have studies done to provide new perspectives on management initiatives in construction planning, the Department of Veterans' Benefits and the VA's supply depot. What are your goals as a manager for the usefulness of these studies and to what degree will the recommendations be factored into planning and budget requests for the future years?

Answer 3. (CONSTRUCTION)

The comprehensive study, awarded in March 1984, to conduct a complete assessment of the VA's organization and procedures for constructing health care facilities, is expected to reduce our lengthy project development time and help ensure that we have the most effective and efficient management, organization and procedural structures available to meet future needs and challenges of VA's construction program. This study is scheduled for completion in April 1985.

A contract study, awarded in September 1983, of VA's design and construction technical standards and specifications will enable a comparison with private sector requirements and identify cost reduction areas. Significant cost reductions are expected to result from this study which is scheduled for completion in the Summer of 1985.

In addition, eighteen consultant contracts to A/E firms have been awarded to survey the physical plant condition and develop corrective plans and cost estimates for 135 VA medical centers. All of these contracts were awarded by the end of FY 1984. All are expected to be completed by November 1985 and will provide VA for the first time ever with comprehensive data on the overall physical plant deficiencies of our medical centers.

We believe these studies will have a significant impact on planning and budget requests for future years. The degree, however, to which the study recommendations will be factored into future years planning and budget requests cannot be assessed until the recommendations have been evaluated and implemented.

Answer 3. (OFFICE OF PROCUREMENT AND SUPPLY)

My goal as a manager is to accomplish an impartial meaningful study of the VA supply system wherein the effectiveness and efficiency of current methods of acquiring and distributing medical supplies, pharmaceuticals and non-perishable subsistence items may be determined. We have contracted with Coopers and Lybrand, a large management consulting firm, which has the capability to provide a study upon which a decision can be made with regard to retention or closure of the depots. I intend to review all recommendations with care and expect to include them in our planning and future budget requests.

Answer 3. (DEPARTMENT OF VETERANS BENEFITS)

Arthur Young and Company completed their study entitled "An Evaluation of the Department of Veterans Benefits Work Measurement System" on March 1, 1985. On March 13, they will conduct a briefing for me to discuss their findings and recommendations. After this briefing and review of the report I will decide what actions are required to improve the DVB work measurement system and provide convincing information in support of department budget requests.

RESPONSE OF THE VETERANS' ADMINISTRATION TO ADVANCE OF HEARING WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A.

With respect to the plan for consolidation of the 59 regional offices of the Department of Veterans' Benefits, I have a series of questions:

Please provide detailed descriptions of the functions, and number of FTEE and number of actual employees to be transferred or lose existing jobs, associated with each of the activities proposed to be centralized: adjudication of compensation, pension, and education claims; loan processing; and support services.

Answer 1A.

ON FEB. 11, 1985 A MEETING WAS HELD BETWEEN THE VA ADMINISTRATOR AND THE DEPUTY OMB DIRECTOR. AT THAT MEETING ALTERNATIVES TO CONSOLIDATION WERE DISCUSSED. CONSOLIDATION WILL BE CONSIDERED BUT SO WILL OTHER MANAGEMENT IMPROVEMENT OPTIONS. UNDER CONSOLIDATION NEITHER THE ORGANIZATIONAL STRUCTURE NOR THE LOCATIONS OF THE CONSOLIDATED CLAIMS AND LOAN PROCESSING CENTERS HAVE BEEN DECIDED. A TASK FORCE WAS RECENTLY ESTABLISHED TO DEVELOP A DETAILED PLAN FOR CONSOLIDATION. THEREFORE, WE ARE NOT IN A POSITION TO STATE DEFINITIVELY HOW CURRENT OPERATIONS WILL BE AFFECTED. HOWEVER, WE DO NOT ANTICIPATE THAT CONSOLIDATION WILL HAVE AN ADVERSE EFFECT ON OUR ABILITY TO CONTINUE THE DELIVERY OF SERVICES TO VETERANS AND THEIR BENEFICIARIES. A BRIEF DESCRIPTION OF AFFECTED AREAS FOLLOWS:

COMPENSATION, PENSION AND EDUCATION - THE PRIMARY FUNCTION OF THIS ACTIVITY IS THE ADJUDICATION OF CLAIMS, ALL OF WHICH WILL BE TRANSFERRED TO THE CONSOLIDATED OFFICES.

LOAN GUARANTY - ONLY THE LOAN PROCESSING ACTIVITY WILL BE TRANSFERRED TO THE CONSOLIDATED OFFICES. THIS ACTIVITY INCLUDES THE DETERMINATION OF VETERANS' ELIGIBILITY, AND THE PROCESSING OF PRIOR APPROVAL AND AUTOMATIC

LOAN SUBMISSIONS. ALL OTHER ACTIVITIES INCLUDING APPRAISAL DEFAULTS AND CLAIMS ACTIVITIES, AND PROPERTY MANAGEMENT OPERATIONS WILL REMAIN AT THE EXISTING REGIONAL OFFICES.

SUPPORT SERVICES - THE MAJOR PORTION OF THE SUPPORT ACTIVITIES WHICH INCLUDES TYPING, FILE MAINTENANCE, MAIL MANAGEMENT, FINANCE AND PERSONNEL WILL BE TRANSFERRED TO THE CONSOLIDATED OFFICES. A SMALL CONTINGENT OF SOME OF THESE ACTIVITIES MAY BE LEFT AT THE EXISTING REGIONAL OFFICES TO PROVIDE SUPPORT TO THOSE ACTIVITIES WHICH FACE THE PUBLIC.

THE ACTUAL NUMBER OF EMPLOYEES TO BE TRANSFERRED OR LOSE EXISTING JOBS IS UNDETERMINED AT THIS TIME. WHEN THE TASK FORCE ISSUES ITS REPORT IN JULY, THE DEPARTMENT WILL BE IN A POSITION TO RESPOND IN GREATER DETAIL. AT THIS POINT, WE EXPECT 2,302 FTEE TO BE AFFECTED BY CONSOLIDATION IN FISCAL YEAR 1986-1988 WITH A REDUCTION OF 624 FTEE IN FISCAL YEAR 1986, 906 FTEE IN FISCAL YEAR 1987, AND 772 FTEE IN FISCAL YEAR 1988. FOR BUDGET PURPOSES, THE FOLLOWING BREAKOUT BY PROGRAM WAS DEVELOPED:

	1986	1987	1988
EXECUTIVE DIRECTION	14	-0-	-0-
VETERANS ASSISTANCE	58	72	54
CP&E	268	369	443
LOAN GUARANTY	(53)	70	45
INSURANCE	17	13	10
VR&C	(10)	52	12
OFFICE SERVICES 1/	[330]	[330]	[208]
ADMINISTRATIVE	145	174	24
FINANCE	161	133	158
PERSONNEL	19	23	26
CARS	5	-0-	-0-
TOTAL DVB	624	906	772

1/ NON-ADD, SUM OF ADMINISTRATIVE, FINANCE, PERSONNEL AND CARS

Question 1B(i).

You have indicated that only functions that do not require face-to-face contact with the veteran would be consolidated. Under your plan --

How would the requests of veterans for hearings before rating boards be met? (In responding, please compare the post-consolidation situation with the present situation in terms of (A) any travel requirements for the veteran,

(B) how soon after the request the hearing would be conducted, (C) the participation of a VA examining physician in the hearing, and (IV) the presence at the hearing of the VA employees who would be making the adjudication decision in the case.)

Answer 1B(i).

AS A MATTER OF DUE PROCESS UNDER THE LAW, ANY CLAIMANT IS ENTITLED TO REQUEST A PERSONAL HEARING TO PRESENT EVIDENCE OR ARGUMENT ON ANY POINT IN HIS OR HER CLAIM. THIS HEARING MUST TAKE PLACE BEFORE PERSONNEL WHO ARE AUTHORIZED UNDER REGULATIONS AND INSTRUCTIONS TO PARTICIPATE IN ORIGINAL DETERMINATIONS ON QUESTIONS AT ISSUE. TO MEET THESE REQUIREMENTS, ANY CONSOLIDATION OF RATING BOARD FUNCTIONS WOULD REQUIRE BOARDS COMPOSED OF 3-4 RATING SPECIALISTS PER BOARD WHO WOULD MAKE REGULARLY SCHEDULED VISITS TO REGIONAL OFFICES TO ACT AS A HEARING PANEL FOR RATING ISSUES.

IT SHOULD BE NOTED THAT RATING ISSUES ACCOUNT FOR ONLY 50-60% OF THE HEARINGS THAT ADJUDICATION DIVISIONS HOLD. JUST AS RATING ISSUES ARE DEALT WITH BY HEARING PANEL CONSISTING OF 2 RATING SPECIALISTS AND A DOCTOR, AUTHORIZATION ISSUES ARE HEARD BY A PANEL OF 3 ADJUDICATORS WHO EITHER HAVE PARTICIPATED IN THE DECISION AT ISSUE OR WHO ARE EXPERIENCED IN THE AREA UNDER DISCUSSION. SIMILARLY, AN ADJUDICATOR IS APPOINTED AS A MEMBER OF THE HEARING PANEL WHENEVER A HEARING IS REQUESTED ON A COMMITTEE ON WAIVERS AND DECISION WHICH INVOLVES AN OVERPAYMENT ARISING IN ONE OF THE PROGRAMS UNDER THE JURISDICTION OF THE ADJUDICATION DIVISION.

DURING FY 1984, 19,160 FORMAL HEARINGS WERE HELD ON RATING OR AUTHORIZATION ISSUES.

(A) TRAVEL REQUIREMENTS FOR THE VETERAN - CURRENTLY THE VA PROVIDES THE HEARING ROOM (IN THE REGIONAL OFFICE) AND THE HEARING OFFICERS, AND PREPARES THE TRANSCRIPT OF THE PROCEEDINGS. ALL OTHER EXPENSES ARE BORNE BY THE CLAIMANT. SINCE REQUIRING A CLAIMANT TO TRAVEL INORDINATE DISTANCES TO ATTEND A HEARING AT THE NEW CONSOLIDATED CENTERS WOULD INFRINGE UPON DUE PROCESS RIGHTS, WE ASSUME THAT CONSOLIDATION WOULD LEAD TO THE ESTABLISHMENT OF TRAVELING HEARING BOARDS WHO WOULD HOLD HEARINGS IN THE "RESIDUAL" REGIONAL OFFICES. THE ADDITIONAL EXPENSE WOULD FALL NOT UPON THE CLAIMANT BUT UPON THE VA. SUCH EXPENSES WOULD ENTAIL NOT ONLY THE TRAVEL AND PER DIEM COSTS FOR THE HEARING PANELS, BUT ALSO THE ADMINISTRATIVE COSTS AND THE CLAIMS PROCESSING DELAYS INVOLVED IN SHIPPING CLAIMS FOLDERS FROM THE CONSOLIDATED CENTER TO THE HEARING SITE SO THAT THEY WOULD BE AVAILABLE FOR PRE-HEARING REVIEW BY THE CLAIMANT AND/OR THE CLAIMANT'S REPRESENTATIVE. (TO THE TANGIBLE COSTS CITED ABOVE MUST BE ADDED THE INTANGIBLE EXPENSES OF TRAINING THE RATING SPECIALISTS AND PHYSICIANS WHO WILL HAVE TO BE RECRUITED TO FILL THE VACANCIES LEFT BY INDIVIDUALS WHO CHOOSE NOT TO RELOCATE.)

B. SCHEDULING OF HEARINGS - PRESENTLY THE DELAY BETWEEN THE TIME A HEARING IS REQUESTED AND THE TIME IT IS ACTUALLY HELD IS DETERMINED BY THE WORKLOAD OF THE ADJUDICATION DIVISION INVOLVED, THE VOLUME OF HEARINGS REQUESTED AT THAT STATION, AND THE NEED TO RESCHEDULE A HEARING IF THE CLAIMANT IS NOT ABLE TO ACCOMMODATE THE DATE ORIGINALLY PROPOSED. THE AVERAGE TIME LAG VARIES FROM STATION TO STATION, WITH 2 WEEKS TO 6 MONTHS BEING THE NORMAL RANGE. WE ENVISION THAT TRAVELING HEARING BOARDS WILL VISIT REGIONAL OFFICES WITH HEAVY HEARING WORKLOADS AT LEAST ONCE A MONTH. STATIONS WITH FEWER HEARING REQUESTS WILL BE VISITED QUARTERLY. DUE TO A NUMBER OF FACTORS IT WILL PROBABLY BE IMPRACTICAL TO KEEP A HEARING PANEL IN THE FIELD MORE THAN 1-2 WEEKS, DURING WHICH TIME THEY WILL PROBABLY BE ABLE TO HOLD 20-25 HEARINGS A WEEK. DURING FY 1984 STATIONS WITH THE HEAVIEST HEARING WORKLOADS RECEIVED, ON AN AVERAGE, 10-25 HEARING REQUESTS A WEEK OR 40-100 PER MONTH. IT SEEMS LIKELY THAT BACKLOGS WILL SHORTLY DEVELOP IN THE BUSIEST STATIONS WHILE CLAIMANTS SERVED IN THE OTHER STATIONS MAY HAVE TO WAIT AS LONG AS 4

MONTHS FOR THEIR HEARINGS (OR 8 MONTHS IF THEY CANNOT ACCOMMODATE THE ORIGINALLY SCHEDULED DATE).

C. PARTICIPATION OF A VA EXAMINING PHYSICIAN - VA EXAMINING PHYSICIANS NEVER PARTICIPATE IN HEARINGS. THEIR ROLE IN THE ADJUDICATIVE PROCESS IS TO CONDUCT EXAMINATIONS AT VA MEDICAL FACILITIES, TO RESOLVE INCONSISTENT OR CONFLICTING DIAGNOSES, AND TO PREPARE THE MEDICAL REPORTS USED BY RATING BOARDS IN THE EVALUATION OF DISABILITY CLAIMS. THE PHYSICIANS WHO PARTICIPATE IN RATING BOARD HEARINGS (38 U.S.C. 3.103(c)) ARE THE DOCTORS WHO ARE REGULAR MEMBERS OF THE RATING BOARDS. IT CAN BE ANTICIPATED THAT MANY OF THESE INDIVIDUALS WILL NOT CHOOSE TO RELOCATE. SINCE A PHYSICIAN WILL HAVE TO BE A MEMBER OF EACH TRAVELING (RATING) HEARING BOARD, OUR ABILITY TO FIELD THESE BOARDS WILL BE AFFECTED BY THE NUMBER OF DOCTORS WHO CHOOSE TO RELOCATE AND OUR ABILITY TO RECRUIT AND TRAIN NEW RATING BOARD DOCTORS. OUR ABILITY TO SUCCESSFULLY RECRUIT NEW PHYSICIANS FOR THESE VERY IMPORTANT POSITIONS WILL BE STRONGLY AFFECTED BY THE LOCATIONS SELECTED FOR THE CONSOLIDATED CENTERS. THE FACT THAT THEY WILL BE REQUIRED TO TRAVEL WILL ALSO HAVE AN IMPACT ON OUR RECRUITMENT EFFORTS.

D. PRESENCE OF DECISION MAKERS - CURRENTLY THE ISSUE OF WHETHER THE HEARING PANEL DOES OR DOES NOT INCLUDE THE INDIVIDUALS WHO MADE THE DECISION AT ISSUE IS DETERMINED BY THE AVAILABILITY OF THOSE INDIVIDUALS (THEY MAY BE ABSENT ON THE DAY OF THE HEARING OR HAVE BEEN REASSIGNED TO OTHER DUTIES) AND BY THE POINT IN THE ADJUDICATION/APELLATE PROCEDURES AT WHICH THE CLAIMANT REQUESTS THE HEARING. GENERALLY, CLAIMANTS WHO REQUEST A HEARING WANT TO MEET, FACE-TO-FACE, THE PEOPLE WHO HAVE MADE THE DECISION ON THEIR CLAIM IN ORDER TO DISCUSS THE REASONS BEHIND THE DECISION AND TO OFFER ARGUMENTS IN THEIR OWN BEHALF. IF THE HEARING IS HELD PRIOR TO THE DECISION, OUR POLICY IS TO HAVE THE "DECISION MAKERS" SIT ON THE HEARING PANEL. HOWEVER, IN THE BEDGOOD VS CLELAND CASE A FEDERAL JUDGE RULED THAT IN ORDER FOR FULL DUE PROCESS TO EXIST, WHENEVER A CLAIMANT REQUESTS A HEARING AFTER A VA DECISION, THE HEARING MUST (WHENEVER POSSIBLE) BE HELD BEFORE A HEARING PANEL WHOSE MEMBERS DID NOT PARTICIPATE IN THE ORIGINAL DECISION.

UNDER A SYSTEM OF TRAVELING HEARING BOARDS, FEW CLAIMANTS WOULD ACTUALLY MEET THE INDIVIDUALS WHO HAD HANDLED THEIR CLAIM. TO ACCOMMODATE THE BEDGOOD RULING THE COMPOSITION OF EACH TRAVELING BOARD WOULD HAVE TO BE TAILORED TO THE DOCKET OF EACH TRIP TO ENSURE THAT "FRESH" RATING SPECIALISTS HANDLED THE HEARING.

AT THIS STAGE OF OUR PLANNING WE ARE ASSUMING THAT THE TRAVELING BOARD WHO HOLDS THE HEARING WILL ALSO MAKE THE SUBSEQUENT RE-REVIEW AND RE-RATING OF THE CASES IT HAS HEARD. THIS PROCEDURE WILL, HOWEVER, CREATE COMPLICATIONS. CURRENTLY, THE PROCEEDINGS OF A HEARING ARE TAPE RECORDED. AS SOON AS THE HEARING ENDS THE RECORDING IS TRANSCRIBED AND USUALLY WITHIN A DAY OR TWO THE TRANSCRIPTION IS PRESENTED TO THE HEARING CHAIRMAN TO BE REVIEWED FOR COMPLETENESS AND ACCURACY. THEN THE HEARING BOARD MEMBERS PROCEED TO REVIEW AND RE-RATE THE CASE. UNDER THE CONSOLIDATED CENTER CONCEPT, THE TAPE RECORDINGS WOULD HAVE TO BE MAILED BACK TO THE "MAIN" OFFICE TO BE TRANSCRIBED. THEY WOULD NOT BE REVIEWED FOR ACCURACY UNTIL THE TRAVELING BOARD RETURNED, PERHAPS A WEEK OR MORE LATER, AFTER THE BOARD HAD HEARD MANY OTHER CASES. FINALLY, GIVEN THE ASSUMPTION THAT THE CONSOLIDATED PROCESSING CENTER WILL BE ORGANIZED BY ASSIGNING RESPONSIBILITY FOR CASES BASED ON TERMINAL DIGITS (AS IS NOW DONE), IN ORDER FOR THE REVIEW AND RE-RATING OF CASES TO BE DONE BY THE MEMBERS OF THE TRAVELING BOARD, THE CLAIMS FOLDERS (WHEN THEY RETURN FROM THE REGIONAL OFFICE) WILL NOT BE PUT BACK INTO THEIR NORMAL CHANNEL OF JURISDICTION BUT WILL BE MIXED WITH THE CASES THAT WOULD NORMALLY BELONG TO THE RATING BOARD MEMBERS WHO HAD MADE UP THE TRAVELING BOARD.

THERE IS ONE MORE ISSUE WHICH SHOULD BE DISCUSSED IN CONNECTION WITH THE ISSUE OF FACE-TO-FACE MEETINGS BETWEEN DECISION MAKERS AND HEARING RECIPIENTS. UNDER THE PRESENT SYSTEM ISSUES UNDER CONTENTION MAY BE RESOLVED BY AN "INFORMAL" HEARING, I.E., THE CLAIMANT OR HIS/HER REPRESENTATIVE DOES NOT ASK FOR A FORMAL HEARING BUT DISCUSSES WITH THE RATING BOARD THE ISSUE OF RECORD. CONSOLIDATION WILL GREATLY REDUCE THE OPPORTUNITY FOR THESE INFORMAL MEETINGS, WITH A RESULTANT INCREASE IN FORMAL HEARINGS.

Question 1B(ii).

Would a veteran applying for a VA-guaranteed home loan be able to obtain his or her certificate of eligibility from a regional office on short notice?

Answer 1B(ii).

YES, VA WOULD STILL PROVIDE ELIGIBILITY CERTIFICATES TO VETERANS WHO MADE DIRECT CONTACT WITH THE REGIONAL OFFICE.

Question 1B(iii).

Would the management and monitoring of fiduciaries be affected?

Answer 1B(iii).

THE PROPOSED CONSOLIDATION PLAN WOULD NOT AFFECT THE VA'S FIDUCIARY AND FIELD EXAMINATION PROGRAM. THE EXISTING ORGANIZATION AND PROGRAM MANAGEMENT WOULD REMAIN IN PLACE SINCE FIDUCIARY AND BENEFICIARY OVERSIGHT INVOLVES FACE TO FACE CONTACTS ON A PERIODIC BASIS.

Question 1C.

A contract was awarded in 1984 to Arthur B. Young and Co. to make a comprehensive study of the DVB work measurement system. I understand that the report is to be completed early this year. Has the consolidation plan been, or will it be, developed based on the findings and recommendations drawn from this study?

Answer 1C.

THE STUDY OF THE WORK MEASUREMENT SYSTEM EVALUATES DVB OPERATIONS UNDER THE EXISTING OFFICE STRUCTURES; IT DOES NOT ADDRESS THE IMPACT OF CONSOLIDATION. WHEN THE STUDY IS RECEIVED, IT WILL BE REVIEWED TO DETERMINE ITS IMPLICATIONS ON OUR CONSOLIDATION EFFORTS.

Question 1D.

It seems to me that one of the keys to the success or failure of any consolidation plan may be the effectiveness of communications and, especially, the Target system. I understand that the Office of

Data Management and Telecommunications has contracted for a "Target Replacement Study". What is the status of that study and what are the agency's plans with respect to keeping the VA up-to-date in this area?

Answer 10.

The current equipment and software maintenance contracts with Honeywell Information Systems, Inc. for the Benefits Delivery Network (Target System) expire on September 30, 1986. In anticipation of this, the Veterans Administration competitively awarded a consultant services contract to Advanced Technology, Inc. on September 29, 1984. Since the draft of the first deliverable of the contract was not due to the Veterans Administration until February 19, 1985, the Veterans Administration is unable to provide substantive results or products to your office at this time.

The purpose of the contract is to obtain a preliminary study of the alternatives available to the Veterans Administration for the continued operation of the Benefits Delivery Network beyond the expiration of the maintenance contracts. The contract specifies four tasks and three deliverables. The tasks include the development of a projection of benefits delivery processing needs through 1995 (Deliverable One); the formulation of preliminary viable alternatives available to the Veterans Administration; a preliminary evaluation of each alternative identified by the previous task; the development of detailed recommendations (Deliverable Two) regarding those few alternatives determined by the Veterans Administration for the contractor's further analysis, and appropriate technical specifications (Deliverable Three) related to the single most feasible alternative.

The contractor is currently involved in the work related to the accomplishment of the first two tasks. The final deliverables will be submitted to the Veterans Administration by June 6, 1985. Upon receipt and review by the Veterans Administration of the final deliverables, copies will be provided to your office.

Question 1E.

Under section 210(b)(2) of title 38, United States Code, the Administrator is prohibited from implementing this administrative reorganization in fiscal year 1986 unless, not later than the date on which the President transmitted the FY 1986 budget to the Congress (February 4, 1985), the Administrator had submitted "to the appropriate committees of the Congress a report containing a detailed plan and justification for the administrative organization." In a February 8, 1985, letter to you (copy attached), I stated my view that your 2-page letter of February 1, 1985, to the Committees on Appropriations and Veterans' Affairs do not constitute such a report. In my letter, I also noted the prohibition in the law against any action to implement a reorganization covered by section 210(b)(2) until the first day of the fiscal year as to which a satisfactory report has been submitted in a timely manner and indicated my view that the prohibition extends to work and expenditures in preparation for the planned personnel moves as well as to the actual personnel transfers and reductions themselves. Please provide an opinion from the VA General Counsel on these same points, i.e., whether your February 1 letter meets the requirements of section 210(b)(2) and what is the scope of the prohibition on "actions to carry out" a reorganization.

Answer 1E.

(The Veterans' Administration's response follows:)

United States Senate
COMMITTEE ON VETERANS' AFFAIRS
WASHINGTON, DC 20510

February 8, 1985

Honorable Harry N. Walters
Administrator of Veterans' Affairs
810 Vermont Avenue, N.W.
Washington, D.C. 20420

Dear Harry,

I am writing in response to your February 1, 1985, letter regarding a planned reorganization and consolidation of certain field office functions of the Department of Veterans' Benefits. In that letter, you stated that you "propose to consolidate DVB benefit processing and support activities from 59 regional offices into 3 processing centers over the course of fiscal years 1986 through 1988."

I share with you a strong desire to improve the efficiency of VA operations and the quality of services. I also believe that the VA should make a concerted effort to take advantage of recent advances in communications and data processing technology in order to make such improvements. However, any actions taken in pursuit of the goal of greater efficiency must, I'm sure you will agree, not be at the expense of service to veterans and be carried out in full compliance with the law.

In your February 1 letter, you stated that you were providing notification "[i]n accordance with" section 210(b)(2) of title 38, United States Code. For the reasons discussed below, I believe that your letter fails to meet the requirements of section 210(b)(2) and that this law prohibits action to implement the planned reorganization during FY 1986.

Under the pertinent provisions of section 210(b)(2), you "may not in any fiscal year implement" a reorganization involving a more-than-10-percent reduction in the number of full-time equivalent employees (FTEE's) at any VA facility with more than 25 employees unless you first submit, not later than the date on which the President submits the budget for that year, to the appropriate Congressional committees "a report containing a detailed plan and justification for the ... reorganization." In my view, your letter falls far short of providing the type of "detailed plan and justification" required by the law. For example, the letter does not even indicate the number of employees who would be moved (either in total or from each regional office) or identify the cities at which the 3 processing centers would be located. Nor does the letter state how the consolidation would make the estimated more than 2,300 FTEE-reduction possible other than through a vague and conclusory reference to "efficiencies possible with consolidation", which I do not view as satisfying section 210(b)(2).

Moreover, the letter was totally ambiguous as to whether employees who adjudicate claims and attend hearings requested by claimants would remain in the regional offices. Your letter said both that claims adjudication activities would be centralized and that "operations involving direct personal contact with veterans and beneficiaries" would not be moved. This raises the question whether the adjudication personnel whose duties involve direct personal contact with veteran-claimants, such as conducting hearings, would or would not be moved.

These and many other questions would have to be specifically addressed in any type of "detailed plan" in my judgment.

I believe that your letter also fails to provide a "detailed ... justification". The mere recitation in the letter of claims that the reorganization would enable you to take advantage of recent technological advances, improve efficiency, and achieve savings is unsatisfactory.

In contrast, I note your letters, also dated February 1, 1985, regarding two other proposed reorganizations: the proposed closing of the three data processing and telecommunications field stations and the transfer of certain functions from the VA Prosthetics Center in New York City to a new Prosthetics Assessment and Information Center (PAIC) in the Washington, D.C., area. Both of these letters set forth in much greater detail the specifics of the proposed, much more limited reorganizations (whether or not the data processing letter contains a "detailed ... justification" as required by the law is an open question in my mind). Indeed, in the case of the proposed PAIC, the letter is accompanied by a description of the implementation actions and a summary of the proposal that discusses justification, organization impact, personnel impact, and fiscal and related impacts.

Indeed, you seem to recognize in the letter on the proposed DVB reorganization that you have not provided the requisite plan. You state that a "task force has been established to develop an implementation plan" and that, in July of this year, this "task force" will provide definitive plans on locations and relocation strategies, as well as detailed estimates on translocation and equipment costs ...." It may be that that plan, if accompanied by specific information justifying the reorganization, would provide the level and kind of detail required.

If such a plan and justification is submitted this year (or any time prior to or concurrent with submission of the President's FY 1987 budget), actions to implement the reorganization could lawfully be initiated in FY 1987.

In light of the extensive work that would be necessary to acquire and prepare the office space at the 3 centers, I would also like to emphasize the prohibition in section 210(b)(2) against any "action to carry out" a reorganization until the beginning of the fiscal year with respect to which adequate notification is given. In my view, the law applies not apply only to the transfer and attrition of personnel but also to all actions preparatory to the personnel moves that would be taken pursuant to the plan. Thus, even assuming that the July 1985 notification of this proposed reorganization will meet the law's reporting requirement, I believe that no work may be done or expenditures incurred to implement the reorganization plan until October 1, 1986, the first day of fiscal year 1987.

As you know, Harry, this reorganization proposal is of great interest and deep concern to many veterans, VA employees, and their families and to all members of the House and Senate. Therefore, I would very much like to learn as quickly as possible your responses to the issues I have raised. In addition, I request that you seek a formal written opinion from your General Counsel as to whether your February 1, 1985, letters regarding the proposed DVB reorganization and the closing of three data processing and telecommunications field stations comply with section 210(b)(2) as to an October 1, 1985, implementation date.

As always, I very much appreciate your cooperation and look forward to your prompt reply.

With best personal regards,

Cordially,

Alan Cranston
Ranking Minority Member

cc: Honorable Frank H. Murkowski
Honorable G.V. (Sonny) Montgomery
Honorable John Paul Hammerschmidt

Office of the
Administrator
of Veterans Affairs

Washington D.C. 20420

Veterans
Administration

MAR 12 1985

Honorable Alan Cranston
Ranking Minority Member
Committee on Veterans' Affairs
United States Senate
Washington, D.C. 20510

Dear Senator Cranston: Alan

Thank you for your letter of February 8 concerning our reported reorganizations of the Department of Veterans Benefits (DVB) and the Office of Data Management and Telecommunications (ODM&T). You raise a number of matters regarding these proposed reorganizations.

As you requested, I have solicited an opinion from our General Counsel regarding the question of the adequacy of our February 1 letter reporting the proposed DVB and ODM&T reorganizations. A copy of that opinion is enclosed.

No final decision has been made as to the specific DVB consolidation proposal. It has been agreed that the Veterans Administration will develop a plan for modernizing its entire operations, and that we will consider various efficiency alternatives, one of which may be DVB consolidation. The DVB effort has just begun however, and, when it is completed, a decision will be made as to the best course of action to be taken concerning DVB. I want to assure you that we will, as always, work closely with you through our oversight committees, and with veterans' organizations to achieve a consensus before proceeding. We do believe that the ODM&T reorganization is appropriate. We will be providing you with additional specifics concerning it, and the DVB proposal.

I am sure that you would agree with the Administration's position that there is, today, an urgent need to work with the Congress to find ways to achieve savings in all Federal programs. We will attempt to do our part. However, while management improvements and greater efficiency can be realized in VA programs, I want to assure you that this will never be done, while I am the Administrator, by sacrificing compassionate, timely, and good quality care and services for our Nation's veterans.

Sincerely,

Harry

HARRY N. WALTERS
Administrator

Enclosure

Veterans
Administration

Memorandum

Date

To Administrator (00)

From Acting General Counsel (02)

Subj Request for our Opinion as to the Legal Sufficiency of the VA's 2/1/85 Letters to Congress Reporting Planned DVB and ODM&T Reorganizations Under 38 U.S.C. § 210(b)(2)

1. The attached letters dated February 1, 1985 reported to appropriate VA oversight committees and subcommittees in the Congress two planned VA administrative reorganizations. One letter concerned the planned DVB consolidation of certain functions from 59 regional offices into 3 processing centers. The second reported the plan to close three ODM&T field stations and transfer their functions to two other VA Data Processing Centers. You request our opinion as to whether these two report letters were sufficient to meet the notice requirements of 38 U.S.C. § 210(b)(2). A second, related question is what kinds of VA activity constitute "implementation," or "actions to carry out" a reorganization, since such activity must be delayed under 38 U.S.C. § 210(b)(2)(A) until the first day of the fiscal year for which the reorganization is reported.

2. Section 210(b)(2)(A) of title 38, U.S. Code requires the VA to submit a "detailed plan and justification" to appropriate committees of Congress for certain planned VA administrative reorganizations. The first issue presented by your request is what degree of specificity must such a plan and justification meet in order to comply with this standard. The terms of the clause are not defined in the statute. It must be acknowledged, however, that the meaning of the term "detailed" is somewhat subjective and is an area where reasonable minds may differ.

3. The legislative history of this provision does not provide a definition as to the standard of specificity or description therefor. This provision was adopted as a Congressional response to an Agency reorganization involving DVB. In that proposal, substantially all DVB regional office functions would have been consolidated into approximately three offices. One of the two subject reorganizations would similarly consolidate significant portions of the local regional offices. It is noteworthy that Congress, in responding to the earlier plan, did not prohibit such a consolidation of DVB, but rather imposed the

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MAY 1983
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notice and wait requirement on any future such reorganization plans, such as the one which is a subject of this opinion. Thus, it is apparent that Congress did not intend to block significant reorganizations so much as to gain time to learn of and evaluate such proposed Agency action.

4. Taken together, the language of the statute, the legislative history and the events giving rise to this legislation, it may be concluded that the subject clause requires that any such report of a planned reorganization provide notice sufficient to enable the Congress to effectively and efficiently mount its own fact finding and evaluative efforts regarding the planned reorganization so as to make its own assessment of whether to attempt to block such action by legislative means. This provision establishes a period of time in which Congress is assured of several months for fact finding, evaluation and effecting a legislative response. Thus, while the statute uses the word "detailed," the degree of specificity must be considered in the context of the overall process.

5. It is quite clear that once a report provides notice to Congress of a proposed plan the VA oversight committees have the experience and resources to closely scrutinize, question, and if necessary block any proposed reorganization. Such oversight is effected regularly and effectively in all VA program and budget areas by the VA committees. This effectiveness is amplified by the "work together" and openness attitude which characterizes the VA's relationship with these committees. This significant, effective oversight process by the VA committees, fully available to them during the lengthy consideration period following submission of the reorganization plan, must be considered in calculating the degree of specificity required by the"detailed plan" requirement of section 210(b)(2)(A). The absence of definition of a standard here, coupled with the lengthy waiting period, underlines further the clear intent that much fact finding would ensue following provision of notice of a planned reorganization. Between antagonists, the requirement for a "detailed" plan might never be satisfied. The fact that there is no statutory resolution mechanism in such an event suggests the intent, born of lengthy experience between the VA oversight committees and the VA, that whatever details may be lacking at the outset would be filled in sufficiently for the oversight committees to make a reasonable judgment on the desirability of a reorganization.

6. The conclusion then, is that while the Agency has a duty under section 210(b)(2)(A) to provide a "detailed," report on any significant VA reorganization, the absence of all of the details, should not, given the context of the Congressional evaluation oversight process established by this section, render invalid a report which, in other circumstances, might fail to meet commonly-accepted standards of what constitutes a "detailed" plan.

7. Applying the foregoing to the subject DVB report, it must be conceded that considerable detail is lacking; that substantive discussions of how much FTEE will be affected, or, how particular, critical affected activities would be administered following reorganization would contribute significantly to the understanding of what is proposed. On the other hand, the Agency stands ready to provide more information as that information is obtained. It is noted that the Agency letter admits that the VA lacks some details regarding the DVB plan. The Agency has given notice of its basic objective. There is no doubt as to the overall intended result. The Agency will be obliged to provide additional information regarding this reorganization plan, however, to enable the oversight committees to evaluate it properly.

8. Although not of great length, the ODM&T submission provides somewhat greater detail, and, when considered in light of the whole process, seems to meet the submission requirement of the subject section.

9. The second question is what kinds of VA action constitute "implementation" or "actions to carry out" a reorganization for purposes of the waiting period requirement. The words of 38 U.S.C. § 210(b)(2)(A) provide that the "Administrator may not . . . implement [a covered] administrative reorganization" until he first submits the required report, and further that "[n]o action to carry out such reorganization may be taken" after submission until the first day of the fiscal year for which the report was submitted. (Emphasis added.) Obviously, any complex VA reorganization involves a great deal of lead time and much activity ranging from early planning, to preparation for relocation of functions and personnel, to the actual execution of the reorganization with movement of people and equipment. Again, in the absence of a statutory or legislative history definition the purpose of the waiting period would appear to be the best guide to the intended meaning of the word "implementation." By providing for a lengthy waiting period, the Congress sought to preserve its option to "veto" a covered reorganization.

10. In light of this purpose, it would be inappropriate for the VA to obligate sizable government resources for a planned reorganization if, during the waiting period, it became reason-

ably apparent that the reorganization would be prohibited by the Congress. However, assuming compliance with the notice provision, we do not believe that the statute generally bars the Administrator from taking steps to commence the movement of personnel and equipment on the first day of the next fiscal year. Submission of such a report is an indication that an Administrator has already determined, in accordance with his statutory responsibilities, that serious pursuit of a reorganization may be in the best interests of program implementation and efficient management. Having made that determination he is obligated to proceed with planning and preparations, so as to permit any actual reorganization to be carried out as soon as possible, once the waiting period has expired. As indicated above, the commitment of resources predicated upon implementation of the plan must be tempered by continuing calculations of whether Congress will block the reorganization. But the fundamental duty of the Administrator to effect the correct management structure requires that prudent resource allocation be undertaken during the waiting period in order to realize the benefits of such reorganization as soon as possible.

11. Presumably, the Congress would only rarely take action to block a reorganization which the Administrator has determined would improve Agency management. Moreover, a measured VA commitment of resources is consistent with the statutory language itself. The language calls for the submission of information about the planned reorganization well before it could be implemented legally, and, contemplates the possible generation of extensive additional information during the oversight waiting period. Thus, the statute itself clearly contemplates that the Agency will expend resources to evaluate, continue evaluating and otherwise plan actual implementation of the reorganization, well before the date before which no actual implementation could take place.

12. Based upon the above, it is our opinion that VA "implementation" action which is prohibited during the waiting period under 38 U.S.C. § 210(b)(2)(A) is the actual carrying out of the reorganization with movement of people and equipment.

ROBERT E. COY

Attachments

Question 1F.

In your February 1, 1985, letter to me regarding this reorganization, you stated that, although the "first move" would not occur until July 1986, a reduction of 624 FTEE is scheduled for FY 1986. You also stated that the total DVB reduction would be more than 2,300 FTEE over fiscal years 1986 through 1988. Please describe how the 624 FTEE reduction was computed and, in doing so, indicate the numbers of employees involved (with a breakdown of part-time and full-time employees) and the approximate dates in FY 1986 they would leave the VA's employ.

Answer 1F.

REALIZING THAT CONSOLIDATION COULD NOT BE IN PLACE UNTIL THE LATTER PART OF FY 1986, A REDUCTION OF 624 FTEE SEEMED APPROPRIATE. SINCE NO DETAILED PLANS ARE IN EXISTENCE WE ARE NOT IN A POSITION TO PROVIDE INFORMATION ON THE NUMBER OF EMPLOYEES INVOLVED NOR THE APPROPRIATE DATES IN FY 1986 THEY WOULD LEAVE THE VA'S EMPLOY.

Question 1G(i) & (ii).

Would there be any reduction in FTEE in the Department of Veterans' Benefits if the consolidation did not occur?

If so, please provide details of numbers of FTEE involved and associated savings.

Answer 1G(i) & (ii).

THERE WOULD BE NO FTEE REDUCTION IN THE DEPARTMENT OF VETERANS BENEFITS IF CONSOLIDATION DID NOT OCCUR.

Question 2. Page 21-5 of the VA's budget notes that the Office of the Associate Deputy Administration for Information Resources Management is to transfer $20,000 to the Department of the Treasury as the VA's portion of the President's Council on Management Improvement Federal Financial Systems of the Future project. Please describe this project and the VA's role in it.

Answer 2. THE DEPARTMENT OF TREASURY'S OFFICE OF THE SECRETARY IS MANAGING A PROJECT, ON BEHALF OF THE PCMI SYSTEMS COMMITTEE, CONCERNING THE FEDERAL GOVERNMENT'S FUTURE FINANCIAL SYSTEMS. THE PROJECT WILL CONSIST OF:

- A SURVEY OF THE HIGH-LEVEL FEDERAL OFFICIALS RESPONSIBLE FOR FINANCIAL SYSTEMS; AND
- AN EFFORT TO IDENTIFY THE ISSUES THAT MUST BE RESOLVED FOR THE FEDERAL GOVERNMENT TO MAKE SIGNIFICANT PROGRESS TOWARDS IMPROVING ITS FINANCIAL SYSTEMS; WHO CAN AND SHOULD RESOLVE THOSE ISSUES; AND THE BASIC SYSTEM ALTERNATIVES.

BECAUSE VA SERVES ON THE PCMI COMMITTEE, VA HAS BEEN INVOLVED IN REVIEWING AND APPROVING THE STATEMENT OF WORK AND MAKING RECOMMENDATIONS REGARDING THE COURSE OF THE PROJECT. WE ALSO REVIEWED AND EVALUATED CONTRACTORS' PROPOSAL. AS THE PROJECT EVOLVES WE PLAN TO BE INVOLVED IN STAFF LEVEL DISCUSSIONS AND REVIEW OF THE CONTRACTOR'S REPORT. OUR GOAL IS TO INSURE THAT THE PRODUCT OF THE PROJECT IS USEFUL TO VA AS WELL AS OTHER FEDERAL AGENCIES.

Question 3.

A. What amount does the VA estimate it would collect in guaranteed-loan funding fees in FY 1986 if (i) the fee were left at one percent, and (ii) raised to five percent as proposed?

B. Please provide a complete description of the analyses and assumptions underlying those estimates.

C. How would the number and total amount of VA-guaranteed loans made in fiscal year 1986 be affected by an increase in the funding fee, effective October 1, 1985?

Answer 3.

A. THE VA ESTIMATES IT WOULD COLLECT $152,600,000 IN FUNDING FEES IN FY 1986 IF THE FEE WERE TO REMAIN AT ONE PERCENT. IF THE FEE WERE TO BE RAISED TO FIVE PERCENT OUR ESTIMATE IS $759,200,000 FOR FY 1986.

B. THESE PROJECTIONS ARE BASED ON THE ASSUMPTION THAT THERE WOULD BE NO CHANGE IN LOAN ORIGINATIONS WITH AN INCREASE IN THE FUNDING FEE FROM ONE TO FIVE PERCENT. IN MOST CASES THE VETERAN WOULD CHOOSE TO FINANCE THE FEE OVER THE LIFE OF THE LOAN AS THIS WOULD ONLY SLIGHTLY INCREASE THE MONTHLY PAYMENT.

C. AS STATED ABOVE, THERE WOULD BE NO CHANGE IN LOAN ORIGINATIONS IN FY 1986 WITH AN INCREASE IN THE FUNDING FEE FROM ONE TO FIVE PERCENT.

Question 4.

Last year, in section 2511 and 2512 of the Deficit Reduction Act of 1984, the Congress made extensive changes in the VA's guaranteed home loan program designed to ensure the solvency of the Revolving Fund. Please provide an analysis of the impact of those changes on the Fund in FY 1985 and those projected for FY 1986.

Answer 4.

THE DEFICIT REDUCTION ACT OF 1984, PUBLIC LAW 98-369, SIGNIFICANTLY IMPROVED THE FINANCIAL CONDITION OF THE LOAN GUARANTY REVOLVING FUND. THIS LAW INCREASED THE FUNDING FEE FROM ONE HALF TO ONE PERCENT AND AUTHORIZED THE FEE TO BE DEPOSITED INTO THE REVOLVING FUND. THESE PROVISIONS WILL RESULT IN AN ESTIMATED $149.2 AND $152.6 MILLION IN ADDITIONAL RECEIPTS TO THE FUND IN FISCAL YEARS 1985 AND 1986 RESPECTIVELY. APPROPRIATION REQUIREMENTS FOR THE FUND, THEREFORE, HAVE BEEN REDUCED BY $301.8 MILLION DURING THIS PERIOD. HOWEVER, THE FUND WOULD STILL, ON A CURRENT SERVICES BASIS, REQUIRE A TOTAL OF $711.2 MILLION IN BUDGET AUTHORITY FOR 1985 AND 1986. THE DEFICIT REDUCTION ACT HELPED, BUT DID NOT SOLVE THE FUND'S FINANCIAL PROBLEMS.

IT IS TOO EARLY TO TELL WHAT SPECIFIC SAVINGS WILL BE REALIZED FROM PROVISION OF THE ACT RELATING TO PROPERTY ACQUISITIONS AND CASH SALES.

Question 5.

On page 16-22 of the VA's fiscal year 1985 budget, the VA projected the workload for the Loan Guaranty Service of the Department of Veterans' Benefits as follows:

Construction and Valuation	821,500
Loan Processing	480,000
Loan Servicing and Claims	1,159,050
Property Management	151,215

On page 21-22 of the fiscal year 1986 budget, the projected workload for the Loan Guaranty Service for fiscal years 1985 and 1986 is as follows:

	FY 1985	FY 1986
Construction and Valuation	651,000	717,000
Loan Processing	479,000	555,000
Loan Servicing and Claims	325,617	293,000
Property Management	76,000	71,000

A. To what do you attribute the reduction in the workload in Loan Services and Claims -- a 71.9-percent decline from the original projection for FY 1985 and an additional 10-percent decline projected for fiscal year 1986?

B. To what do you attribute the reduction in Construction and Valuation and Property Management in FY 1985 from the levels first projected?

Answer 5.

A. VA HAS CHANGED THE METHOD OF COUNTING WORKLOAD ITEMS FOR LOAN SERVICE AND CLAIMS AND PROPERTY MANAGEMENT. IN PRIOR YEARS PORTFOLIO LOAN SERVICING, ONE OF THE KEY WORKLOAD ITEMS FOR LOAN SERVICE AND CLAIMS, WAS STATED AS A YEARLY AVERAGE MULTIPLIED BY 12. FOR EXAMPLE, IF VA HAD AN AVERAGE OF 100,000 PORTFOLIO LOANS IN INVENTORY THIS WAS REPRESENTED AS 1,200,000 WORK UNITS FOR THE YEAR. AS VA EXPERIENCED SIZABLE LOAN SALES, HOWEVER, THE CHANGE IN WORK UNITS TENDED TO DISTORT THE TRUE LEVEL OF WORK IN THIS FUNCTION WHICH WAS INCREASING DUE TO HEAVY DEFAULTS AND FORECLOSURES. THE PERCENT CHANGES IN YOUR QUESTION FOR LOAN SERVICE AND CLAIMS, THEREFORE, ARE NOT COMPARABLE. WE EXPECT LOAN SERVICE AND CLAIMS TO DECLINE IN FY 1985 AND FY 1986 REFLECTING A REDUCTION IN DEFAULTS AND FORECLOSURES.

B. THE ESTIMATE FOR FY 1985 REFLECTS OUR LATEST INFORMATION AVAILABLE REGARDING APPRAISAL ACTIVITY NATIONWIDE. THE ORIGINAL FY 1985 ESTIMATE WAS MADE IN LATE 1983 WHEN VA WAS EXPERIENCING HEAVY APPRAISAL WORKLOADS RELATED TO REFINANCING ACTIVITY. SINCE THAT TIME THE REAL ESTATE MARKET HAS SOFTENED NECESSITATING A CHANGE IN WORKLOAD ESTIMATE FOR THIS ACTIVITY.

VA MADE A CHANGE IN THE METHOD OF COUNTING UNITS OF WORK FOR PROPERTY MANAGEMENT SIMILIAR TO THAT MADE FOR LOAN SERVICE AND CLAIMS. IN PRIOR YEARS THE AVERAGE NUMBER OF PROPERTIES IN INVENTORY WAS MULTIPLIED BY 12 MONTHS TO ARRIVE AT ONE OF THE KEY WORK COUNTS. WE HAVE REVISED THIS COUNT TO DELETE THE MULTIPLICATION OF THE AVERAGE BY 12. THE ORIGINAL FY 1985 ESTIMATE IS, THEREFORE, NOT COMPARABLE WITH THE LATEST ESTIMATE. IN ADDITION, THE ORIGINAL FY 1985 ESTIMATE WAS BASED ON THE POLICY OF NO PROPERTY ACQUISITIONS BEGINNING MARCH 1, 1984.

VA'S LATEST ESTIMATE FOR PROPERTY MANAGEMENT CONTEMPLATES A STEADY REDUCTION IN PROPERTY INVENTORY IN LINE WITH AN INTENSIFIED SALES EFFORT.

Question 6.

On page 2-8 of the VA's budget, in connection with the loss on defaulted guaranteed loans, the average amount per payment on a defaulted loan in the case of a single-family residential property is projected to jump by about 30 percent from fiscal year 1985 to fiscal year 1986 -- from $11,505 to $14,944. To what do you attribute this increase, which I note is substantially more than the 6-percent increase in the case of manufactured homes?

Answer 6.

PROVISIONS OF THE DEFICIT REDUCTION ACT OF 1984 CHANGED THE CRITERIA VA APPLIES IN DETERMINING THE NET VALUE OF PROPERTIES SECURING FORECLOSED GI LOANS. THE LAW REQUIRES VA TO DEDUCT A FULL RANGE OF PROPERTY DISPOSITION COSTS FROM THE APPRAISED VALUE IN ARRIVING AT THE NET VALUE. VA ESTIMATES THAT THIS CHANGE WILL INCREASE THE INCIDENCE IN WHICH VA PAYS GROSS CLAIMS IN LIEU OF ACQUIRING PROPERTIES. WE THEREFORE PROJECT SHARPLY HIGHER AVERAGE CLAIM PAYMENTS IN BOTH FY 1985 AND 1986. HOWEVER, THIS INCREASE IS OFFSET BY A LARGE DECLINE IN PROPERTY ACQUISITION COSTS.

Question 7.

On page 16-23 of the VA's fiscal year 1985 budget, the VA projected an FTEE of 464 for administration of the VA's insurance programs in that year. On page 21-23 of the fiscal year 1986 budget, you are now projecting an FTEE of 530 for fiscal year 1985 for this activity. What accounts for the increase in FTEE associated with this operation?

Answer 7. ON OCTOBER 1, 1984 THE INSURANCE COLLECTION ACTIVITY AND THE INSURANCE AWARDS AND VOUCHER AUDIT ACTIVITY WERE TRANSFERRED FROM THE FINANCE DIVISION TO THE INSURANCE DIVISION AT THE PHILADELPHIA REGIONAL OFFICE AND INSURANCE CENTER. THIS TRANSFER IN WORKLOAD AND THE COMMENSURATE EMPLOYMENT, ACCOUNTS FOR THE INCREASE IN FTEE.

Question 8.

Please provide a breakdown of the workload of the Vocational Rehabilitation and Counseling service (appearing at page 21-26 of the VA's budget), for each of fiscal years 1984, 1985, and 1986, in terms of the activities associated with the chapter 31 program of vocational rehabilitation for service-connected disabled veterans, the Emergency Veterans' Job Training Act of 1983, each of the two pilot programs established by sections 111 and 301 of Public Law 98-543, and counseling for those participating in education and training programs under chapter 32, 34, or 35.

Answer 8.

FY 1984

	CH. 31	EVJTA	PL 98-543 301	 111	CH. 32, 34 & 35
COUN/EVAL	79,971	186			
COUN (OTHER)		15,125			16,762
REHAB/EMPLOY	188,500				
SUPPORT SVCS	2,199,241	134,406			25,602
TOTAL	2,467,712	149,717			42,364

FY 1985

COUN/EVAL	84,170	90	7,500	4,800	
COUN (OTHER)		8,125			13,744
REHAB/EMPLOY	190,675		8,100	1,200	
SUPPORT SVCS	2,012,704	60,314	89,250	17,125	22,500
TOTAL	2,287,549	68,529	104,850	23,125	36,244

FY 1986

COUN/EVAL	93,584	35	8,000	480	
COUN (OTHER)		4,000			21,584
REHAB/EMPLOY	184,819		23,250	4,700	
SUPPORT SVCS	2,037,499	30,000	128,750	24,700	53,960
TOTAL	2,315,902	34,035	160,000	29,880	75,544

Question 9.

As is noted at page 5-11 of the budget documents, the FY 1985 Medical Care appropriation was $24.7 million over the President's request and provided for the employment of 620 FTEE more than the President had proposed. Of the additional FTEE, 220 were to be added to the readjustment counseling program and the balance of 400 were to be used by the VA "in such high-priority areas as outpatient services, gerontology, psychological services and unit dose."

A.(i) Were the 220 additional FTEE and the funds to support them provided to the readjustment counseling program? Please specify the amount of funds provided for these FTEE.

(ii) How were the additional FTEE and funds used in that program (please breakdown by location and job function)?

B. What was the disposition of the remaining 400 FTEE and the funds to support these FTEE? Please specify the amount of funds provided for these FTEE and also describe specifically the extent to which any of these additional FTEE were used (i) to enhance the agency's efforts to provide treatment for veterans suffering from PTSD, (ii) for converting additional beds to the unit dose system, (iii) for improving the core staffing at VA psychiatric facilities, (iv) for improving existing alcohol dependence programs, and (v) for creating new psychiatric intensive treatment programs.

Answer 9.

A(i). In 1985 appropriation action, Congress provided an additional 220 FTEE for the expansion of the readjustment counseling program. The readjustment counseling program was provided a net increase of 220 FTEE and $5.3 million in 1985. The in-house program was provided $8.5 million and 220 FTEE for the establishment of 52 vet centers. This provides for a total of 188 vet centers in 1985. The increase in the in-house program was offset by a $3.2 million congressionally directed reduction in the contract program.

(ii). The attached charts depict the additional FTEE by location for augmentation and expansion. Augmentation staffing includes additional Counselors for existing Vet Centers and administrative support and contracts oversite positions for regional offices. Associated staffing for expansion includes a Team Leader, two Counselors, and secretarial support for a 4-person Vet Center; a Team Leader, one Counselor, and secretarial support for a 3-person Vet Center; and two Counselors for a 2-person Vet Center Satellite. In addition a chart is provided that distributes the appropriation action increase, FTEE and dollars by region.

B. In 1985 an additional $24,730,000 and 620 FTEE were provided to the Medical Care appropriation. A net total of $5,300,000 and 220 FTEE were provided to the readjustment counseling program. Distribution follows (dollars in thousands):

PROGRAM	B. A.	FTEE	IMPACT
Outpatient visits.	$8,060	161	Additional 80,600 visits
Bone Marrow.......	1,200	10	Expand Seattle unit from 4 beds to 8 beds
Post Traumatic Stress Disorder.	2,600	70	$1.4 million and 30 FTEE provided for a PTSD center in Cleveland; remainder will establish two new PTSD centers (Phoenix and American Lake), enhance some of remaining 10 centers
Unit dose.........	1,700	85	Convert an additional 2,380 beds
Adult day health care...........	$ 1,376	34	Establish 4 new centers; to handle approximately 35,000 visits
Geriatric Evaluation units....	1,324	34	Enhance staffing at 17 existing centers (2 per center).
VIST coordinators	240	6	Establish 6 coordinators; to handle 2,100 visits
Community nursing	3,930	...	Directed by Congress; will support 178 census
Subtotal increase.......	20,430	400	
Travel (.007) reduction........	-1,000	...	Directed by Congress
Readjustment counseling.....	5,300	220	
Total increase.	$24,730	620	

REGION I

AUGMENTATION SITES

FACILITY		FTEE
Albany, NY Vet Center		1.0
Babylon, NY Vet Center		1.0
Bangor, ME Vet Center		1.0
Brooklyn, NY Vet Center		1.0
Montrose, NY Vet Center		1.0
Providence, RI RM Staff Office		4.0
White Plains, NY Vet Center		1.0
	Subtotal	10.0

EXPANSION SITES

FACILITY		FTEE
Arecibo, PR Satellite		2.0
Lowell, MA Satellite		2.0
New Bedford, MA Satellite		2.0
Norwich, CT Satellite		2.0
Ponce, PR Satellite		2.0
Rochester, NY Satellite		3.0
Syracuse, NY Vet Center		4.0
Worcester, MA Satellite		2.0
	Subtotal	19.0

Region I Augumentation/Expansion Total 29.0

REGION II

AUGMENTATION SITES

FACILITY		FTEE
Baltimore, MD RM Office		2.5
Fayetteville, NC Vet Center		1.0
Harrisburg, PA Vet Center		1.0
Philadelphia, PA Vet Center		1.0
Pittsburgh, PA Vet Center		1.0
Richmond, VA Vet Center		1.0
Roanoke, VA Vet Center		1.5
	Subtotal	9.0

EXPANSION SITES

FACILITY		FTEE
Charleston, WV Satellite		1.0
Erie, PA Vet Center		4.0
Fairfax County, VA Vet Center		4.0
Greensboro, NC Vet Center		4.0
Johnson City, TN Vet Center		3.0
Martinsburg, WV Satellite		2.0
Roanoke, VA Vet Center		4.0
Rocky Mount-Jacksonville, NC Vet Center (Greenville)		4.0
Scranton, PA Vet Center		3.0
Southern NJ Vet Center		4.0
	Subtotal	33.0

Region II Augmentation/Expansion Total 42.0

REGION III

AUGMENTATION SITES

FACILITY		FTEE
Bay Pines, FL RM Office		3.5
Knoxville, TN Vet Center		1.5
Knoxville, TN Vet Center		1.0
Little Rock, AR Vet Center		1.0
Miami, FL Vet Center		1.0
New Orleans, LA Vet Center		1.0
	Subtotal	9.0

EXPANSION SITES

FACILITY		FTEE
Biloxi, MS Satellite		2.0
Chattanooga, TN Vet Center		4.0
Columbia, SC Satellite		2.0
Palm Beach County, FL Vet Center		4.0
Pensacola, FL Vet Center		3.0
Sarasota, FL Vet Center		3.0
Savannah, GA Vet Center		4.0
Shreveport, LA Vet Center		4.0
Tallahassee, FL Vet Center		4.0
	Subtotal	30.0

Region III Augmentation/Expansion Total 39.0

REGION IV

AUGMENTATION SITES

FACILITY		FTEE
Chicago, IL RM Office		2.0
Cincinnati, OH Vet Center		1.0
Cleveland, OH Vet Center (1 each)		2.0
Dayton, OH Vet Center		1.0
Ft. Wayne, IN Vet Center		1.0
Grand Rapids, MI Vet Center		1.0
Indianapolis, IN Vet Center		1.0
Madison, WI Vet Center		1.0
Milwaukee, WI Vet Center		1.0
Peoria, IL RM Staff Office		3.0
	Subtotal	14.0

EXPANSION SITES

FACILITY		FTEE
Chicago (NS), IL Vet Center		4.0
Gary, IN Vet Center		4.0
Springfield, IL Vet Center		4.0
St. Louis, MO Satellite		2.0
	Subtotal	14.0

Region IV Augmentation/Expansion Total	28.0

REGION V

AUGMENTATION SITES

FACILITY		FTEE
Dallas, TX RM Staff Office		1.5
Denver, CO RM Office		3.5
Kansas City, MO Vet Center		1.0
Salt Lake City, UT Vet Center		1.0
	Subtotal	7.0

EXPANSION SITES

FACILITY		FTEE
Austin, TX Vet Center		4.0
Boulder, CO Vet Center		4.0
Corpus Christi, TX Vet Center		3.0
Houston, TX Vet Center		4.0
Missoula, MT Vet Center		3.0
Moline-Rock Island, IL Vet Center		4.0
Pocatello, ID Vet Center		3.0
Provo, UT Satellite		2.0
	Subtotal	27.0

Region V Augmentation/Expansion Total 34.0

REGION VI

AUGMENTATION SITES

FACILITY		FTEE
Los Angeles, CA RM Office		2.0
San Diego, CA Vet Center		2.0
San Francisco, CA RM Staff Office		2.0
Seattle, WA Vet Center		1.0
	Subtotal	7.0

EXPANSION SITES

FACILITY		FTEE
Amarillo, TX Vet Center		3.0
Eureka, CA Vet Center		4.0
Lubbock, TX Vet Center		3.0
Medford, OR Satellite		2.0
Midland, TX Satellite		4.0
Prescott, AZ Vet Center		4.0
Sacramento, CA Vet Center		4.0
Salem-Corvallis, OR Vet Center		3.0
San Bernardino County, CA Satellite		2.0
San Diego County, CA Satellite		2.0
Santa Barbara, CA Vet Center		4.0
Santa Cruz, CA Vet Center		4.0
Sante Fe, NM Satellite		2.0
	Subtotal	41.0
	Region VI Augmentation/Expansion Total	48.0

SUMMARY OF AUGMENTATION/EXPANSION FTEE AND FUNDING BY REGION

	Augmentation	Expansion	Total FTEE	Total Funding
Region I	10	19	29	$1,142,496
Region II	9	33	42	$ 786,311
Region III	9	30	39	$1,346,667
Region IV	14	14	28	$1,101,912
Region V	7	27	34	$1,196,320
Region VI	7	41	48	$2,113,346
Program-Wide	56	164	220	$7,687,052
Funding to be Allocated				$ 812,948
Total Funding				$8,500,000

Question 10. With further reference to the FY 1985 Medical Care appropriation, at page 5-11 of the budget documents, it is noted that the total FTEE level included in that appropriation was 193,941. The FTEE level proposed in the budget documents for FY 1986 is 192,048, a reduction of 1,893 FTEE. However, of the FTEE level requested for FY 1986, 2,068 FTEE are for new activations as described beginning at page 5-30 of the budget documents, which means that only 189,980 of the FTEE proposed for FY 1986 are for existing programs. This means that the personnel resources for FY 1986 for existing programs will be reduced by nearly 4,000 FTEE -- 3,961 -- from the level specifically authorized and appropriated for by Congress for the current fiscal year.

A. Is this analysis incorrect in any way? If so, how?

B.(i) Will this very significant reduction of 3,961 FTEE be made in a proportionate manner across the system and across the many different types of personnel positions in DM&S or will there be a disproportionate impact in some geographic regions or on some specific types of personnel?

(ii) Please provide the details in either case.

C. How many VA health-care personnel who are currently providing direct patient-care services will be eliminated as a result of this FTEE reduction?

(In responding to questions B and C, please specify the types and numbers of personnel affected and the facilities affected.)

Answer 10.

A. Although it could be interpreted as you described, it is not a complete description. It is important to note that most of the FTEE for activations are not for new programs or additional workload, but for existing programs to operate new equipment or renovated space. What is described are the FTEE changes that take place in FY 1985 and 1986 including the reallocation of employment resources necessary to accomplish planned activations for 1986 and assuming a modest 1 percent productivity improvement.

B. The FTEE reductions are in response to several different mandates or initiatives and will be dealt with incrementally according to the mandates. All reductions and off-setting increases will be netted by facility using the following process:

1. **The Resource Allocation Models will first be applied for FY 1986 and adjustments will be made to individual facilities. After the facilities' have the base adjusted by the models, the FTEE absorptions will be calculated.**

2. **For the 1,916 FTEE to improve productivity, 32% of this reduction (613) will be assessed to all facilities based on the proportion of their indirect FTEE to all indirect FTEE. Indirect costs and costs not included in the Resource Allocation Models (for acute, ambulatory, and long term care) used for FY 86, average 32% systemwide.**

3. **The remaining 1,300 will be assessed to medical centers based on their relative efficiency as measured by methods derived from the Resource Allocation Models (RAM). Under this method only facilities whose efficiency per direct care FTEE is below the system norms developed from the RAMs will be reduced on a proportionate basis. This will be applied to the 68% of facility costs that are direct medical care as measured by the RAMs.**

4. **After facilities have their basis adjusted through the steps above, their relative efficiency will be measured again using indicators derived from the RAMs. VAMCs with**

relatively lower efficiency will be assessed FTEE reductions on a proportionate basis to make up the 2,045 FTEE needed for activations and other purposes.

5. Every hospital that has an addition of FTEE because of activations or other reasons, will have that gain netted against any FTEE reductions assessed to it for the 1% productivity factor and for its relative efficiency.

6. All facilities will have some FTEE reduction calculated for their indirect costs and costs not measured by the RAMs, and some facilities will have FTEE reductions assigned to the direct services measured by the RAMs. However, the net reduction or gain in FTEE will not be assigned to any specific categories and the facility directors will make the decision as to how the FTEE change should be spread.

C. As described above in "B", the reduction in FTEE will be calculated by assigning a reduction of 613 indirect FTEE proportionately, and the remaining 3,348 will be calculated on the direct FTEE in the RAMs according to relative efficiency. However, even though the reductions will be calculated on indirect and direct FTEE, the facility director will have the flexibility to make those reductions where he/she sees fit as long as the dollar reduction is met.

Question 11.

With reference to the conversion of approximately 440 existing hospital beds to intermediate hospital and nursing home care beds described at page 5-16 of the VA budget documents:

A. Please provide a listing showing --

(i) a breakdown of the types of personnel affected by the conversion (e.g., physician, nursing, other direct patient care, or other);

(ii) the facilities where the conversions will take place, specifying for each facility (I) the number and type of intermediate or nursing home care beds that will result, (II) the number of FTEE for the beds, both prior to and following conversion, with breakdowns according to the types of personnel affected (e.g., physician, nursing, other direct patient care, or other) and (III) the reduction in funds at each facility related to the conversion;

(iii) the timetable at each facility for the conversion;

(iv) the change at each facility in average operating beds; and projected average daily census as a result of the conversion

(v) the extent to which the agency's aggregate census in intermediate hospital and nursing home care beds will be affected by this conversion.

B. Please provide information on how the facilities that are scheduled to carry out this conversion were selected?

C. Please describe the process for converting a bed from a hospital bed to an intermediate care bed or to a nursing home care bed in terms of the time involved for each type of conversion (specifying the time that such a bed would be out of use), the cost of each type of conversion (including the cost of any renovation), and the FTEE reduction associated with each type.

D. Will all expenditures for renovations be from medical care funds?

E. (i) What are the current average core staff ratios for medical beds, for surgical beds, for psychiatric beds, for intermediate care beds, and for nursing home care beds?

(ii) Will this be changed after these conversions are completed?

Answer 11.

The MEDIPP process identified the cumulative impact of the proposed budget actions of 172 VAMCs. Within this total, the VAMCs indentified the following bed changes:

	Beds
Medical.............	- 37
Surgical.............	-262
Psychiatric.........	-144
Intermediate........	+239
Hospital..........	-204
Nursing.............	+204
Net..............	...

These bed changes were interrelated to many other VAMC initiatives including new programs, existing program enhancements, increased turnover of patients, etc.

The bed reconfiguration and conversion initiative included in the 1986 Budget not only identifies those resources saved from reducing costly inpatient hospital beds but also the additional resources required to support the converted nursing home beds. Using current operating costs the resources reduced from inpatient (using the bed distribution identified by MEDIPP) would be $23,222,000 and 521 FTEE and the resources to support increased nursing home requirements would be $7,752,000 and 220 FTEE.

The hospital bed reconfiguration/conversion will be operationally implemented as part of the resource allocation (target allowance) process identified in the answer to question 10B.

To the individual VAMC involved, the "building-up" MEDIPP process (summation and interrelation of all VAMC initiatives) will be different from the "feeding down" process on budget implementation (which provides the VAMC with the net result of all budget decisions). The total allocation process will ultimately establish the resource shifts at individual VAMC's.

A.(i) The allocation process will determine (by individual VAMC) the resources changes associated with the bed changes. The types of personnel affected will ultimately be determined by the individual VAMC director.

(ii thru v) The bed, census, FTEE and resource distribution at each VAMC will be impacted by the net result of all budget decisions (i.e. activations, program improvements, absorptions, decreased requirements for productivity increases, etc.). Not until the target allowance process is finalized and the actions of the VAMC directors assessed can these questions be fully addressed.

B. Individual facilities identified the bed changes in their MEDIPP submissions.

C. The means of conversion, the beds impacted, and the resource change (both dollars and FTEE) are totally dependent upon the individual facility's present and future workload demands, the VAMC's physical capacity (structure, physical plant, reconfiguration of existing beds versus requirement of new beds, etc.) and present medical services provided. Some of the conversions may be as simple as changing the staffing on a ward and others are more complicated.

D. Little or no renovation resources are required for these conversions, but any that may be would be funded from within the Medical Care appropriation.

E. Core staffing ratios are no longer monitored by the VA. Total staffing ratios (direct plus indirect FTEE/census or 1,000 patients treated) are not materially affected by the bed conversion, because workload and employment relationships are maintained as resources are shifted between activities.

Question 12.

In response to a question regarding the then-forthcoming VA report on aging veterans ("Caring for the Older Veteran") that I asked last year during Committee consideration of the VA's budget for FY 1985, the agency noted that

> When the resource requirements for implementing the report's recommendations are known, appropriate resources [for DM&S], in the form of a 1985 program supplemental or a 1986 initiative, will be presented during the 1986 budget formulation process. (Page 199 of the Committee's February 8, 1984, Hearing on the Veterans' Administration fiscal year 1985 Budget.)

Although that report, when completed and finally issued, allowed for a great deal of flexibility in how DM&S might meet the challenge of the aging veteran population, it clearly recognized the need for substantial growth in the VA health-care system.

A. How is the commitment made last year during the ~~FY~~ 1986 budget hearing to seek the resources to carry out the recommendations in the "Caring for the Older Veteran" report carried out in proposed budgets for both fiscal years 1985 and 1986? (In responding to this question, please note how these budgets will help DM&S meet the five goals and the nineteen objectives for DM&S specifically set forth in "Caring for the Older Veteran", pp. 9-10.)

B. Please indicate the resources (both in terms of FTEE and dollars) that DM&S devoted in fiscal year 1984 and plans to devote in each of fiscal years 1985 and 1986, to the following activities:

-- Hospital-Based Home Care Programs (HBHC)
-- Geriatric Research, Education, and Clinical Centers (GRECC)
-- Geriatric Evaluation Units (GEU)
-- Adult Day Health Care Services (ADHC)
-- Hospice Programs
-- Programs to coordinate VA programs with appropriate community programs.

C. What efforts are ongoing or planned for either fiscal year 1985 or 1986 to evaluate the cost-effectiveness of HBHC programs, GEV's, ADHC programs, respite care, and any other programs designed to meet the needs of older veterans in non-institutional settings?

D. What did the VA spend for the report, "Caring for the Older Veteran", and the agency's participation in the collaborative project with the Division of Health Policy Research and Education at Harvard University and the joint VA-American Health Planning Association Conference entitled "The Complex Cube of Long-Term Care"?

Answer 12A.

First, it is important to keep in mind that "Caring for the Older Veteran" is not a plan, but a series of options for meeting the health care requirements of the aging veteran population. As the Administrator of the VA has emphasized, the options in the report and the assumptions which underlie them can and must be debated. The issues in the report have major implications for the nation's health care system as a whole. Consequently, the Congress, the veterans service organizations, the principal health care financing programs and provider organizations must be involved together with the VA and other members of the Administration, e.g., White House Working Group on Health Policy in determining an affordable and acceptable way to meet the increasing needs. We expect that the necessary decisions will take a year or so.

Nevertheless, while the larger decisions affecting the entire health care system are being made, the VA has taken the challenge of dealing with the older veterans' needs very seriously and continues to be committed to providing high quality, comprehensive health care to all eligible veterans. For the older veteran, this has meant incorporating special programs related to medical, psychiatric and rehabilitative care into existing acute care and outpatient programs, as well as expansion of several extended care programs.

The 1985 current estimate has enabled the VA to make some progress toward meeting the needs identified in the report, "Caring for the Older Veteran," and the FY 1986 budget request will continue to meet these needs plus allowing for minimal expansion of additional resources pertinent to those requirements. We feel that the initiatives listed below amply demonstrate that the VA is continuing to plan and implement programs for the older veteran. The 1985 current estimate reflects the impact of the Congressional add-on to the original 1985 budget request,

Highlights of the initiatives proposed in the 1985 and 1986 budgets to meet the increasing care needs of older veterans are listed below:

1985 Current Estimate

(1) Seventeen existing Geriatric Evaluation Units (GEUs) received an additional two FTEE per unit. Total number of GEUs is 40 (23% of VAMCs).

(2) Six more Hospital Based Home Care (HBHC) programs for a total of 49.

(3) Five additional Adult Day Health Centers (ADHC) for a total of 9.

(4) Eleven new VA Nursing Home Care Units for a total of 116. It is anticipated that the nursing home census will increase by 915 in 1985 to a level of 9975.

(5) Resources provided to fully support ten Geriatric Research, Evaluation and Clinical Centers (GRECCs) in 1985.

(6) Thirteen State Home Care construction and renovation projects continued or initiated to support an increase in 733 State Home Nursing Care census in 1985 over the 1984 level; and an increase in State Domiciliary census of 68.

(7) Community Nursing Home census increased by 830 over the 1984 level; this includes the impact of the $3.9 million Congressional add-on in 1985.

(8) Staff outpatient visits increased by 100,000 over the 1984 level for a total of 17,035,000 visits. The increase reflects both an increase in existing facilities and the impact of activations in 1985.

(9) Research funds were requested for the following projects related to the older veteran:

a. Eighteen (18) proposals of scientific merit on the basic biological processes underlying aging.

b. Biomedical research related to aging conducted in two recently established GRECCs.

c. A cooperative study to evaluate the efficacy of Physostigmine in the Treatment of Alzheimer's Disease.

d. Evaluation of the Adult Day Health Care Program.

e. Research related to preventive care and cost effectiveness.

(10) Educational funds were requested to support geriatric/gerontology programs:

a. Fifty-four medical centers to support 103 associated health geriatric trainees in such fields as social work, psychology, optometry, audiology and speech pathology.

b. Forty-five masters degree students in geriatrics/gerontology nursing.

c. Twenty-four more physicians and five dentists supported by geriatric fellowships.

1986 Proposed Budget

The 1986 budget request for the Medical Care appropriation provides for the continuation of the above programs plus modest program increases. Several initiatives which provide for expanded health care to the aging veteran are listed below:

(1) Provide resources to fully fund forty-nine Hospital Based Home Care (HBHC) programs. The 1985 budget provided first year resources for an additional six HBHC programs. In 1986 resources are requested to fully support these six programs. The total number of programs will be forty-nine.

(2) Census in VA nursing homes will increase by 866 in 1986. The additional census (for a 1986 total census of 10,841) will be provided by the conversion of 204 hospital beds to nursing home care beds (190 census), a realignment of resources from the hospital activity to the VA nursing home activity due to delays in facility activations (376 census), and scheduled activations in 1986 (309 census).

(3) An increase of 618 census is anticipated in the State Home Nursing Care program to a 1986 level of 8818. It is also estimated that the State Home Domiciliary census will increase by 248 to a level of 4717.

(4) It is anticipated that outpatient visits will increase by 120,000 in 1986 to a level of 17,155,000. This increase is the result of the anticipated impact of facility activations in 1986. Total staff and fee visits will be 18.8 million in 1986.

Answer 12B.

Hospital Based Home Care

Medical Care
Hospital Based Home Care
(dollars in thousands)

	1984	1985	1986	Change
Budget Authority	$ 12,974	$ 14,739	$ 15,271	$+ 532
FTEE	370	400	414	+ 14
Teams	43	49	49	...
Home Visits	199,000	203,258	204,938	+ 1,680
ADC	2,668	2,878	2,998	+ 120

The above chart provides the latest estimate of resources and workloads associated with the Hospital Based Home Care (HBHC) Program. In addition to adding 12 teams in 1984, a new HBHC Program was activated in Tampa, and the Little Rock program was enhanced. The 1985 budget includes resources for 6 additional teams. The 1986 increase of $532,000 and 14 FTEE reflects: annualization of the 1985 increase ($708,000 and 18 FTEE); uncontrollable increases to the program ($394,000 for within grades, pay annualization, and inflation); partially offset by the 5 percent pay reduction ($450,000 in 1986) and 1 percent productivity increase (reduction of $120,000 and 4 FTEE).

Geriatric Research, Education, and Clinical Centers (GRECCs)

GRECCs
(dollars in thousands)

	1984		1985		1986		Change	
	B.A.	FTEE	B.A.	FTEE	B.A.	FTEE	B.A.	FTEE
Medical Care	$ 6,029	127	$10,769	171	$ 9,547	169	$-1,222	-2
MAMOE	340	2	362	2	375	2	+ 13	...
Research	2,056	57	2,150	62	2,050	60	- 100	-2
Total	$ 8,425	186	$13,281	235	$11,972	231	$-1,309	-4
No. of GRECCs	10		10		10		...	

The above chart provides the latest estimates of resources associated with the GRECC Program. In 1986, $9,547,000 and 169 FTEE (Medical Care appropriation) will continue to support the 10 established GRECCs. The reduction of $1,222,000 and 2 FTEE in Medical Care from the 1985 estimate reflects: a reduction in one time capital investment, and maintenance and repair costs associated with fully funding two GRECCs in 1985 (reduction of $1,079,000); the government-wide pay reduction and productivity increase (reduction of $398,000 and 2 FTEE); offset by uncontrollable increases for inflation and within grades ($255,000). GRECCs through their research and educational component will provide a resource that enhances the VA ability to treat the aging veteran at all facilities.

Geriatric Evaluation Units

Medical Care
Geriatric Evaluation Units
(dollars in thousands)

	1984*	1985	1986	Change
Budget Authority	...	$1,324	$1,301	$ -23
FTEE	...	34	34	...
Units	39	40	40	...

*In FY 1984 there was no specific budget authority for GEUs. VA medical centers operated 39 GEUs using available FTEE and funds provided for VA hospital operations. FTEE assigned and costs distributed were not separately identified for GEUs.

Additional resources from the FY 1985 appropriation have been distributed to VA medical centers to provide two additional staff for each of 17 existing Geriatric Evaluation Units. The resources (dollars and FTEE) listed above reflect additional funding of these existing 17 GEUs.

In FY 1986 the VA will continue the operation of existing Geriatric Evaluation Units. Activation of any new GEUs at this time will be through redesignation of beds and program activities, with reprogramming of existing resources as appropriate. The reduction of $23,000 in 1986 reflects the government-wide 5 percent pay reduction (-$49,000) offset by uncontrollable payroll increases for normal salary increases and annualization of the January 1985 pay raise ($26,000).

Adult Day Health Care

Medical Care
Adult Day Health Care
(dollars in thousands)

	1984*	1985	1986	Change
Budget Authority	...	$1,376	$1,386	$ +10
FTEE	...	34	34	...
Centers	4	9	9	...

*In FY 1984 there was no specific budget authority for ADHCs. VA medical centers operated 4 ADHCs using available FTEE and funds provided for VA hospital operations. FTEE assigned and costs distributed were not separately identified for ADHCs.

Additional resources from the FY 1985 appropriation are being used to provide for 4 ADHCs located at VA Medical Centers Little Rock, Arkansas; Miami, Florida; Minneapolis, Minnesota; and Portland, Oregon. The resources listed above reflect funding requirements for these four centers. Activation of these ADHCs will result in a total of 9 ADHCs in operation. The 5 other ADHCs were funded from available resources, 4 prior to FY 1984 and 1 in FY 1985.

In FY 1986 the VA will continue the operation of existing ADHCs and begin studying the medical efficacy and cost effectiveness of this program. An additional $10,000 will be required to support the 4 newly established centers in 1986. A $35,000 reduction resulting from the government-wide 5 percent pay cut is offset by uncontrollable increases in payroll ($18,000) and the inflationary impact on non-payroll items ($27,000).

Hospice Programs

There is only one Central Office funded Hospice Program which is located at the West Los Angeles (Wadsworth) Medical Center. All other hospice activities are supported by VA medical centers from VA hospital operations resources, and FTEE and costs distributed are not reported separately. The estimated resources for the Wadsworth VA Medical Center Palliative Treatment Program are reflected in the following chart.

Palliative Treatment Program
(dollars in thousands)

	1984*	1985	1986	Change
Cost	716	$ 750	$ 743	$ -7
FTEE	20.5	20.5	20.5	...
Days of Care				
Inpatient	3,229	3,230	3,262	32
Home	8,914	8,915	9,004	89

The reduction of $7,000 from the 1985 estimate reflects: the government-wide pay reduction (reduction of $25,000); offset by uncontrollable increases for inflation ($5,000) and within grades ($13,000).

Programs to coordinate VA programs with appropriate community programs.

The VA is involved in many significant ways in coordinating with appropriate community programs on a continuing basis. For example, as a part of MEDIPP, Medical Districts must assure that in their planning efforts opportunities for cooperation are identified and fully developed. In planning for patient discharge, such opportunities are explored and utilized for the placement of patients. The VA also provides information and referral services for older people in participation with 15 Federal departments and agencies. The costs of these and other similar activities are not separately identified from VA hospital operation costs. Any estimate of FTEE and dollars would be very subjective.

Answer 12C.

The Department continues to assess the efficacy of the medical and health related programs. Evaluations of the benefits and effectiveness compared to the cost of other programs continue and currently demonstrate some promising results.

HBHC is a significant alternative to long term care institutionalization in a nursing home. Various studies of home health care programs have been showing positive cost benefits. However, the definitive answers to cost effectiveness have yet to be concluded. The VA will evaluate these studies and propose any additional program evaluations to determine the cost effectiveness of the program.

Studies of GEUs within and outside the VA have demonstrated certain values to this modality of comprehensive assessment of the elderly patient. One study conducted at the VA GRECC at Sepulveda has been reported on in a special article in The New England Journal of Medicine, December 27, 1984. The article entitled "The Effectiveness of a Geriatric Evaluation Unit" described a randomized clinical trial of assigning frail elderly inpatients with a high probability of nursing home placement to a GEU. It was concluded that GEUs can provide substantial benefits at minimal cost for appropriate groups of elderly patients, over and above the benefits of traditional hospital approaches. More work needs to be done in order to be completely certain of their cost effectiveness.

ADHC is considered to be another alternative to long term institutionalization in a nursing home. ADHC is in the early stages of development and when additional programs are activated it will be possible to conduct the health services research study required by Public Law 98-160.

No studies have been conducted to evaluate the cost effectiveness of respite care. The VA has not established respite care as a program. We are proposing legislation for a pilot respite care program and an evaluation of the program before we would continue it.

The GRECCs have been the subject of several evaluations and are currently under assessment by the Office of Policy, Planning and Evaluation (07). The GRECCs have already demonstrated their value as centers of excellence consistent with the mandates in the law. Annual reports demonstrate preliminary positive findings as to their cost effectiveness.

Management Information Systems and "national" evaluation strategies for all these programs are in process and, hence, more definitive data will be available in the near future. This information will be critical to more definitive analyses of efficacy and the usefulness of these programs.

Answer 12D.

The organization, preparation, and completion of the three projects, the Aging Report, the Harvard Collaborative Project, and the joint VA-AHPA Conference extended,

respectively, over 22, 8, and 9 months. Each project varied in the expenditure of resources and the contributions/commitment of VA staff support.

The chart below presents the costs directly attributable to these three projects. These costs include staff and consultant salaries, conference registration fees, travel and per diem, supplies and printing.

	Costs ($ in thousands)
Aging Report	**$482**
Harvard Collaborative Project	**$199**
VA-AHPA Conference	**$401**

Question 13.

At page 5-16 of the budget documents, it is noted that hospital requirements will be reduced in FY 1986 by $14.3 million and 378 FTEE "to realign VA nursing home care requirements."

A.(i) Where, by facility, are these resources currently located and will they be realigned at each such facility?

(ii)(I) If not, to where, by facility, will they be shifted?

(II) When did these facilities receive the resources in question and to what use have they been put since being received?

(III) Do you anticipate any significant impact on inpatient census or core ratios at any individual facilities as a result of such realighment?

Answer 13.

A.(i). The nursing home realignment identifies resources originally budgeted to activate nursing homes but not utilized due to project slippage. The project slippage allowed these funds to be temporarily used by the facility for hospital activity. The realignment concept redistributes resources to reflect the activity breakout as originally budgeted.

Listed below are the facilities and resources comprising the 1986 realignment of $14,279,000 and 378 FTEE between the VA hospital and nursing home activities (dollars in thousands):

Facility	**B.A.**	**FTEE**
Ann Arbor, Mi..........	**$ 1,011**	**27**
Atlanta, Ga...........	**545**	**14**
Boise, Id.............	**389**	**10**
Dallas, Tx............	**973**	**26**
Fresno, Ca............	**1,595**	**42**
Kerrville, Tx.........	**934**	**25**

Facility	B.A.	FTEE
Marion, Il.............	506	13
Portland, Or...........	2,023	54
Richmond, Va...........	934	25
Seattle, Wa............	1,011	27
Spokane, Wa............	389	10
Tampa, Fl..............	934	25
Washington, D.C........	584	15
W. Los Angeles, Ca.....	2,451	65
Total	$14,279	378

(ii)(I) The resource realignment does not reflect a transfer between facilities as much as a transfer between activities. That is, the budget reflects a transfer from the hospital activity to the nursing home care activity.

(II) The majority of the nursing homes on the realignment list (A)(i) were originally scheduled to be activated in 1985. A few projects were budgeted to be activated prior to 1985 and the 1986 realignment reflects annualization of these slipped projects. The resources made available to the facility by these project slippages are primarily used on a non-recurring basis in the hospital activity.

(III) The realignment of resources between the hospital and nursing activities does not have any significant impact on hospital workloads. Since the FTEE levels are small, both system-wide and by facility, there is no impact on either workload or staffing ratios. As previously mentioned, the primary purpose of realignment is to reflect the staffing levels and ratios for the hospital and nursing activities as originally budgeted.

Question 14. At page 5-19 of the budget documents, there is a discussion of a planned 8,000 outpatient-fee-visit reduction in FY 1986 with an associated savings of $1.6 million.

A. Please describe the "administrative controls" that will bring about this reduction.

B. Will this reduction be proportionate system-wide or do you anticipate disproportionate reductions in certain geographic areas and, if so, where will such reductions take place?

C.(i) How many of the 8,000 fee visits will become VA staff visits?

(ii) What will be the resource impact (in terms of both FTEE and dollars) of this shift to staff visits?

Answer 14.

A. The following "administrative controls" will be used to reduce the 8,000 visits.

1) Clinics of jurisdiction will continue to reexamine beneficiaries whose fee treatment cards expire, and conduct thorough examinations of first time applicants for fee cards to ensure the medical need for such care.

2) Where indicated, treatment plans will be requested from fee care providers for clinic directors review. As indicated, modifications to proposed treatment schedules will be affected to ensure justifiable quality care.

3) Established monthly dollar limitations will be adhered to. Expenditures exceeding the $75 limit will be approved only after review and concurrence of the clinic director is obtained.

B. The administrative controls, which will result in a reduction in fee workload, will be administered system-wide. It is important to clarify two things. First, the 8,000 reduction in medical fee cases will result in savings totaling $979,000. The remaining $630,000 savings is the result of a 1,000 case reduction in dental fee workload.

C.(i). Since medical fee treatment is limited to service-connected veterans, all of these veterans would be high priority patients at the VA medical center. Therefore, all of the referred fee patients that report to VA facilities, will be treated.

(ii). The transfer of medical fee patient workload to VA facilities is not associated with additional resources in 1986. Since the patients transferred from the medical fee programs to VA facilities are service-connected, these patients will receive medical care.

Question 15. At page 5-32 of the budget documents, it is noted that a new satellite outpatient clinic will be activated in Ponce, Puerto Rico, during FY 1986.

A. Why is there no information about the number of visits that this clinic will handle?

B.(i) When will the funding and FTEE be assigned to this clinic in FY 1986?

(ii) What will be the annualized funding and FTEE for this clinic beginning in FY 1987?

C. Once this outpatient clinic is activated, what will be the impact on the outpatient fee program in the Ponce area?

D. What is the projected level of expenditures for all forms of VA health care in Puerto Rico in FY 1985 and FY 1986 (broken down in terms of appropriation account, level of care, and basic function, including contract and direct care)?

E. Do you propose an extension of the section 601(4)(C)(v) of title 38, United States Code, contract authority in Puerto Rico and the Virgin Islands and, if so, for how long a period?

F. When will the Committee receive the plan relating to VA health care in Puerto Rico and the Virgin Islands called for in the Explanatory Statement accompanying final action on H.R. 5618 (as set forth on page S 12898 of the Congressional Record for October 3, 1984)?

Answer 15.

A. The projected workload for the Ponce Clinic is 42,500 visits when fully activated.

B. (i) The Funding for the Ponce Clinic is scheduled to be distributed in the 3rd Quarter of FY 1986:

26 FTE	$ 715,000
All Other Recurring	357,000
Equipment	2,125,000
Other Non-Recurring	250,000

(ii) FY 1987 Funding and FTE:

85 FTE	$2,338,000
All Other Recurring	1,190,000

C. It is our estimate that once the Ponce Clinic is fully activated $1.6 million in fee basis expenditures will be saved.

D. Levels of expenditures -- by allotment ledgers:

Appropriation	
Medical Care - 3650160 (870)	$100,755,604
General Post - 36x8180 (999)	29,168
Medical Research - 365/60161 (821)	482,017
Education & Training - 3650152 (813)	38,975

Direct Care	$ 73,887,169
Contract Hospitalization	20,441,988
Community Nursing Home	860,308
Medical Fee	3,894,652
Dental Fee	433,391
Contract Dialysis	601,338
Outreach	569,226

E.

The Veterans Administration is planning to propose a three-year extension of this authority.

F.

The report requested by the Veterans Affairs Committee is completed and is undergoing executive review.

Question 16.

A.(i) What are the funding and FTEE levels proposed for the readjustment counseling program for FY 1986?

(ii) What are the funding and FTEE levels for this program in FY 1985?

(iii) What was the final funding and FTEE allocation for this program in FY 1984. Please provide a breakdown of the funds spent on the direct service and fee-for-service portion of the program.

B.(i) How many Vet Centers and how many Satellite Centers are planned for FY 1986?

(ii) What is the timetable for establishing each new Vet Center or Satellite Center in FY 1985?

C. What dollar amount will be devoted to fee-for-service readjustment counseling in each of fiscal years 1985 and 1986?

D. How many FTEE are being used in fiscal years 1985 and 1986 to monitor the fee counseling contracts?

E. How many FTEE will be assigned to the Central Office Readjustment Counseling Service out of the MAMOE appropriation and how many FTEE will be assigned to regional readjustment counseling functions in fiscal years 1985 and 1986?

F. Given the fact that the President's budget (pages 9-12 through 9-16) and VA budget documents (pages 28-2 through 28-5) set forth VA and Medical Care account figures for FY 1987 and 1988, what levels of funds and FTEE do you anticipate will be provided for the readjustment counseling program in those years?

Answer 16.

A. (i) Full utilization of 794 FTEE is anticipated for the fiscal year. The FY 1986 budget will be the FY 1985 base ($40,621,000) plus increases for inflation and any pay requirement changes. We cannot project the estimate for FY 1986 until annual budget plans have been submitted to VA Central Office and approved in final form.

(ii) Present funding for Readjustment Counseling is $40,621,000 and 794 FTEE for FY 1985.

(iii) In 1984 Readjustment Counseling was allocated $33,197,000 and 574 FTEE. The total obligations for FY 1984 were $32,891,000 comprised of $9,403,000 fee-for-service, $1,610,000 PTSD Contract and $21,878,000 direct service.

B. (i) With 52 new sites opening in FY 1985, the total Vet Centers and Satellites operational by the end of the fiscal year will be 189. There are no additional openings anticipated in FY 1986.

(ii) We project that all of the 52 new Vet Centers and Satellites will be fully operational by July 1985.

C. The dollar limit for fiscal years 1985 and 1986 for fee counseling contracts is $8 million.

D. Thirteen positions are slotted for monitoring the fee/contracts program in fiscal years 1985 and 1986.

E. Currently 11 FTEE are assigned to Readjustment Counseling Service in VA Central Office. The impact of the MAMOE budget cutbacks on this staff cannot be assessed at this time. No assignments at the regional level fall under the MAMOE appropriation. Total regional positions charged to the Medical Care Appropriation in Fiscal Years 1985 and 1986 will be 62 FTEE.

F. Outyear projections for fiscal years 1987-1990 reflect the best current estimate of budget resources required for future system capacity. However, because the eligibility reform could alter the ways in which veterans use the system, the allocation of budget resources to and within the medical system could change in future years. Within this amount the level of resources provided for readjustment counseling in fiscal years 1987 and 1988 would be sufficient to support the workload levels attained in fiscal year 1986.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN FOLLOW-UP QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

With respect to the VA's proposed construction budget in fiscal year 1986, I realize that between the time the VA submits its five-year medical facility construction needs assessment and the time that the budget is submitted, projects can be refined, reassessed, and developed so that differences in estimated costs result. However, with respect to a number of specific projects, the differences are so great that I believe an explanation is needed. Please provide a justification for the differences in the costs shown in the five-year needs assessment and the fiscal year 1986 budget for each of the following projects:

Project (Dollars shown in millions)	5-Year Plan	FY 86 Budget
Hines, Illinois - 180-Bed Psychiatric Replacement	$44.0	$23.0
Knoxville, Iowa - Fire/Safety Improvements	13.5	3.7
Topeka, Kansas - Fire/Safety Improvements/Privacy and Electrical improvements	16.0	10.0
Poplar Bluff, Missouri - Electric System Improvements	7.7	2.0
Cleveland, Ohio (Brecksville) - Fire/Safety Improvements	10.0	2.7

Answer 1.

The $44 million estimate for the Hines 180-Bed Psychiatric Replacement Project was prepared for "Air Conditioning and Patient Privacy" to buildings 50, 51, and 53. The cost was not changed to reflect the estimate for the 180-Bed replacement project. In addition, the $44.0 million estimate used a project inflation rate of 12% for 1981 and 11% therafter while the $23.0 million estimate contained a projected inflation rate of 5.2% for 1985, 5% for 1986 and 4.8% thereafter.

In each of the remaining four projects, the scope and cost estimate as reflected in the needs assessment, were prepared at the field level. When actual project development through the Advance Planning process was undertaken, it became apparent that the extent of the corrective measures needed were not as extensive as the facility envisioned. These projects now have completed preliminary plans and estimates which are reflected in the FY 1986 budget request.

Question 2.

The $9.9 million construction project proposed for St. Louis, Missouri, involving the remodeling of building 53 had previously been shown in the 5-year needs assessment as a $4 million project scheduled for fiscal year 1987. What accounts for the more than doubling in cost of this project and the fact that it is being proposed to advance forward a year?

Answer 2.

Building 53 at the VA Medical Center, St. Louis (Jefferson Barracks) Missouri, was originally planned to be seismically strengthened as part of the fiscal year 1986 Seismic Corrections project. To avoid disruption of medical center activities and to allow for prudent planning, it was decided to include the seismic work as part of the project to Remodel Building 53, thus increasing the cost of the project. The decision was made to advance this project since a valid estimate was available for budget consideration.

Question 3.

The $18 million project proposed for the Chicago VAMC (Westside Division) involving the renovation of buildings 11A and 11B was not identified anywhere as a priority in last year's 5-year needs assessment. What considerations led to its inclusion in the VA's fiscal year 1986 budget request?

Answer 3.

The fiscal year 1984 major construction budget included funds to renovate the ground, first, and second floors of Buildings 11A and 11B at VAMC Chicago (Westside), Illinois. It is the intent of this fiscal year 1986 major project request to complete the renovation of the third through the sixth floors of both buildings. The decision to include this project in the fiscal year 1986 budget request was made in support of the medical center's desire to appropriate major construction monies to complete the entire renovation of both buildings. It was determined that it would be more prudent to submit a request for a separate major construction project. Elements considered in making this decision were the avoidance of any possible conflict with Public Law 98-45; the Agency's policy guidance regarding the funding integrity for planning and completing capital improvement projects; the elimination of phasing difficulties associated with completing the scope of the project using minor and minor miscellaneous construction funds over a period of several years; cost reduction potential; and the earlier utilization of much needed renovated space.

Question 4.

Please provide a justification for the manner in which the Philadelphia and Houston projects are proposed for split-year funding -- that is, why the Houston project is to be funded in FY 1986 at 84 percent of the amount necessary to complete the project and the Philadelphia project at only 11 percent?

Answer 4.

Given the constraints in the monies available in the Replacement/Modernization category, split-year funding was proposed which would result in the least interruption to the construction schedule for the two hospitals. The 11 percent allocated for Philadelphia in FY 1986 would allow construction of the Phase 2 Nursing Home Care portion, while the 84 percent for the Houston project would provide for the new hospital. The remaining 16 percent would be for demolition and renovation of the few existing structures to be retained.

Question 5.

I understand that you are considering as an alternative to the DVB consolidation plan a means to modernize DVB operations through ADP and telecommunications technology. For the record, please describe the alternative plan and give us your views on the advantages and disadvantages of these two approaches.

Answer 5.

The Administrator has issued a management directive for implementation throughout the Agency to provide better service to the veteran through modern technology. The directive consists of six key guidelines:

1. Proposed changes are to be assessed from the vantage point of the veteran;

2. each employee must have appropriate on-line access to those data bases needed for his/her job;

3. systems and equipment must be designed for easy use by nontechnical personnel;

4. VA staff must be relieved of paperwork burdens; and

5. capitalize on experience of others in our planning efforts; and

6. organizational roles must be better defined.

DVB has already developed a strategic plan for developing information systems that would meet the objectives of the modernization directive.

The Administrator has arrived at an agreement with OMB to evaluate DVB's proposed consolidation in light of the Agency's modernization directive. VA is establishing a task force which will include an independent management consultant to examine the issue and develop recommendations and alternatives. The Administrator will deliver the findings to OMB in July 1985.

Question 6.

Please explain in detail precisely how the DVB consolidation plan proposed in the FY 1986 budget differs, if at all, from the plan first conceived in 1981.

Answer 6.

To accommodate employment projected in the March amendment of the Fiscal Year 1982 budget, VA planned a reduction in force at regional offices to reduce Fiscal Year 1981 budgeted employment for the Department of Veterans Benefits by 1,879 FTE before October 1, 1981. All personnel outstationed from parent locations were included in this reduction in force. No firm plans were made, but regionalization of all claims and loan guaranty paperwork processing activities was considered. Subsequent executive acceptance of the Gramm-Latta alternative to the House Budget Committee Resolution (expressed to Chairman G.V. (Sonny) Montgomery of the House Veterans Affairs Committee) nullified further action on the reduction in force.

The budget proposes that, beginning in FY 1986, the VA will streamline the DVB field structure by consolidating into three locations with high productivity rates those functions that do not require face-to-face contact with veterans. Specific functions to be consolidated would include the adjudication of compensation and pension claims, administration of education benefits, processing of mortgage loan guarantee applications, and administrative activities. On February 11, 1985, the VA Administrator met with the Deputy OMB Director. At that time, it was agreed that VA would develop a plan for modernizing its entire operations and would consider various efficiency alternatives.

Question 7.

The Administration is proposing to repeal the authority to transfer funds from the Direct Loan Revolving Fund to the Loan Guaranty Revolving Fund. In the justification for this proposal, the VA's budget states: "Transfer authority from the Direct loan revolving fund will no longer be requested, thereby showing the true cost of the loan guaranty program."

A. Do you believe that the true cost of the loan guaranty program would really be hidden if this transfer authority were to continue to exist and be used?

B. (i) Aren't the purposes for which both funds were created to meet the needs of veterans for housing?

(ii) If so, if funds are available in either fund why shouldn't they be used to meet those needs?

C. According to the budget documents, the Direct Loan Revolving Fund is expected to have an unobligated balance of $77.7 million at the end of fiscal year 1985 and of $122.3 million at the end of fiscal year 1986. Inasmuch as the VA apparently plans no expansion of the Direct Loan program and estimates only 15 loans to be made in each of fiscal years 1985 and 1986 from this fund, to what use, other than transfer to the Loan Guaranty Revolving Fund, would these unobligated balances be put?

Answer 7.

A. Eliminating transfer authority between the funds would provide a clearer picture of the cost of the Loan Guaranty Revolving Fund at first glance.

B. (i) In prior budget submissions, the Agency was authorized, in appropriation language, to reapportion funds, as required, from the Direct Loan Revolving Fund to the Loan Guaranty Fund in order to fully support the program. The 1986 President's budget eliminated the appropriation language authorizing the transfer of funds from Direct Loan to Loan Guaranty. However, a legislative proposal transmitted to Congress amending section 1824 of U.S.C. 38, would authorize the transfer of up to $75 million to the Loan Guaranty fund from Readjustment Benefits. However, the funds would have to be restored to readjustment benefits prior to the next fiscal year.

(ii) OMB has made a policy decision that each fund associated with the Veteran's housing program be separate and distinct in regard to both revenue and expenditures.

C. These funds would be available only for expenses of the Direct Loan Program.

Question 8.

A. The VA's budget documents indicate, on page 2-19, that the VA's inventory of real property increased by 9.9 percent from 1983 to 1984 and had an estimated value of $814 million. Isn't it a fact that to the extent that the VA is able to reduce its inventory by selling those properties the need for an appropriation to the Loan Guaranty Revolving Fund will be reduced?

B. What increased effort is the VA making to dispose of its inventory in the most efficient and expeditious fashion?

C. From 1982 to 1983, the total of VA inventory property sales and redemptions increased by 71 percent. From 1983 to 1984, it increased by 19.3 percent. Yet, the budget indicates that from 1984 to 1985 sales will increase by only 10.7 percent and that from 1985 to 1986 sales will actually drop almost 21 percent. I understand that some of the percentage drop may occur because the VA will acquire fewer properties and therefore have fewer properties for sale. However, I fail to understand why, if the VA is making appropriate efforts to dispose of its inventory, the agency would have an end-of-year inventory of more than 18,000 properties. Please explain why this end-of-year inventory and the reduction in the increased sales does not represent a slackening of the VA's efforts to reduce inventory.

D. I note that as of September 30, 1984, there were actually 12 percent more properties in "aboslute title" in the VA's inventory than there were on September 30, 1983, and that a greater percentage of these properties had been in the inventory for 12 months or more. Doesn't this indicate that the VA could be doing more to dispose of its inventory?

Answer 8.

A. Yes, property sales generate revenue to the fund. Greater than anticipated property sales, therefore, could lessen appropriation requirements.

B. Although we have continued to see continuing high levels of foreclosures completed during the past 2 years (an average of 2,360 per month during 1983 and 1984), we have been able to make encouraging progress with our property sales results during 1984 and expect to accelerate sales further during 1985 to reduce our inventory and to minimize the demands on the Loan Guaranty Revolving Fund.

VA took several steps recently to promote property sales. Some of these efforts were as follows:

- A task force composed of field and Central Office employees visited various field stations. The field stations visited had the highest concentration of VA-owned properties. Extensive discussions were held with field station staffs and private sector professionals including mortgage lenders and real estate brokers regarding property dispositions. Many barriers to the sale of acquired properties were identified and eliminated. Further field stations have implemented a much more agressive pricing philosophy.

- As to all properties which remain unsold after six months of market exposure, reasonable offers (below stated list prices) are invited, in order to promote a bargaining - type atmosphere on our older inventory properties.
- Sales commission bonuses of up to $500 are offered on older and lower-priced properties, in order to focus more broker attention on these hard-to-sell properties.
- Discounts of 10% of the list price are offered to purchasers who pay all cash.
- Reasonable loan discount points are paid, when obtaining outside financing so requires.
- We held a test auction of 200 hard-to-sell properties in Detroit in October. It was the largest real estate auction in Michigan history. We are going forward to use this technique during 1985 in other locations where we have difficult inventory problems.

C. VA's FY 1986 budget projects a turnaround in property inventory in FY 1985. These budget estimates reflect fewer property acquisitions due to an improving economy and the provisions of the Deficit Reduction Act. To date in FY 1985 we have not experienced any discernable turnaround in the rate of property acquisitions. We believe our sales efforts have achieved positive results as evidenced by our large sales volume. We are, however, hesitant to predict a larger drop in inventory by the end of FY 1986. At the end of January 1985 the inventory stood at 21,585. VA will have to reduce the inventory 175 properties a month for the next 20 consecutive months to achieve the end of FY 1986 figure of 18,086.

D. Although we have been steadily improving our sales performance, we recognize that the velocity of our sales has, until the past 12 months, not kept up with the velocity of new acquisitions. For example, we began FY 1983 with 17,164 properties in title, sold 18,550 properties during that fiscal year, but still finished the year with a net increase in the inventory. Again, in FY 1984, we started with 19,872 properties, sold 22,144 properties during the year, yet still finished with a net increase of 10% in the inventory at the end of September 1984.

During FY 1984, the percentage of our inventory which had been in title 12 months or more did increase from 28.6% to 30.4%. This can be attributed to two principal factors. First, our more aggressive pricing strategy, emphasized during 1984, was applied initially to the most recently acquired properties which were coming up for their first pricing analyses. Second, properties on hand the longest are generally the hardest to sell, since many brokers shift their sales efforts to more newly-listed properties and since the properties on hand the longest lose some of their sales appeal through deterioration and vandalism.

To counteract this growth in the more aging portion of the inventory, we have taken the following steps:

- reasonable, below-list price offers will be considered for any properties still on the market after 6 months.
- sales commission bonuses of up to $500 may be paid for the sale of properties still on the market after 6 months (or of any property listed for less than $20,000).
- 1985 sales goals have been established for field personnel:
    - in general, no properties to remain in title more than 24 months, and
    - not more than 15% of properties to be in the "over-12 month" category.

In addition, in order to continue the decline in our inventory even in the face of high acquisition levels, we have set an overall 1985 sales objective to sell at least 10% more properties than are acquired.

Question 9.

You noted in your response to my prehearing questions (Question 3B) that, if the veteran elects to finance the fee over the life of the loan, it would "only slightly increase the monthly payment." Please compute the following examples both in terms of monthly payments and total payments (in principal and interest) over the life of the loan:

Example 1 - The purchase of an $80,000 home with no money down and a 1-percent fee that is not financed.

Example 2 - The purchase of an $80,000 home with no money down and a 1-percent fee that is financed.

Example 3 - The purchase of an $80,000 home with no money down and a 5-percent fee that is financed.

Example 4 - The purchase of an $80,000 home with a 5-percent down payment and the purchase of a private mortage insurance policy (assuming that the insurance is dropped when the loan-to-value ratio is reduced to 70 percent).

(For the purposes of examples 1, 2, and 3, use the current VA maximum interest rate for a 30-year fixed-rate mortgage. For example 4, use the best interest rate currently available for a 30-year fixed-rate conventional mortgage with a 5-percent downpayment.)

Answer 9.

Example 1 - Monthly Payment = $854.40
Total Payments (in principal and interest) = $307,584

Example 2 - Monthly Payment = $862.94
Total Payments (in principal and interest) = $310,660

Example 3 - Monthly Payment = $897.12
Total Payments (in principal and interest) = $322,963

Example 4 - Based on a poll of 30 of the largest mortgage banking firms conducted on February 15, 1985, the range of contract interest rates quoted on 95% loan-to-value conventional mortgages was 12.5% (plus 2.25 discount points) to 13.25% (and no points). Our computations are based on the following set of circumstances:

Purchase Price: $80,000
Down payment: $4,000
Loan Amount: $76,000
Term: 30 year
Interest rate: 12.5%
Monthly Mortgage Insurance Premium: 3/8% of outstanding principal balance

The monthly payment (principal and interest) would equal $811.68. The monthly mortgage insurance premium would begin at $28.50 and would decline to approximately $16.40 when the loan-to-value ratio is reduced to 70 percent (sometime in the 23rd year of the 30 year mortgage). The total payments in principal and interest would be $292,204. The total payment for private mortgage insurance would be approximately $6,900.

Question 10.

It seems to me that, if the loan origination fee is raised to 5-percent and the veteran is permitted to finance the fee, what has been created, assuming that no down payment was made on the purchase of a home, is a situation where there is a loan-to-value ratio of 105 percent. In this case, it would seem to be much easier for the veteran-homeowner (who then has little, if any, equity in his or her home for a much longer period of time) who encounters difficulties with making mortgage payments to walk away from the mortgage and go into foreclosure. Such a result would mean that costs of the VA program would increase substantially. Please comment on this analysis.

Answer 10.

If the loan origination fee is raised to five percent and the veteran finances the fee on a no-down-payment loan, there will be a loan-to-value ratio of 105 percent. However, the VA already makes loans with a 101 percent loan to value ratio. We do not anticipate a significant change in the foreclosure rate by increasing this to 105 percent. Any additional costs that might result from the increased loan-to-value ratio may be offset by the additional revenues generated by the increased fee.

Question 11.

In its testimony, The American Legion notes -- in connection with your plans for consolidation of DVB -- that "the complexity of claims has increased due in part to issues such as the effects of exposure to Agent Orange and radiation, and the pathology of Post-Traumatic Stress Disorder, thus requiring more man hours per case." Please comment on this statement.

Answer 11.

Claims processing has increased in complexity due to legislative changes in the past few years. Generally, certain types of claims require more extensive development with outside agencies and consideration of more complex medical issues, such as PTSD, Agent Orange exposure and radiation exposure. Increasing emphasis on due process also has placed additional responsibilities on personnel in DVB.

Question 12.

On page 1 of your statement, you note that legislation is being proposed to restrict the use of the VA health-care system by "non-exempt" veterans whose income exceeds an eligibility level. For the record, please list the "certain categories of other veterans" who would be exempt from this means test.

Answer 12.

Those veterans exempt from the means test are:

1. Service-connected veterans for service-related disabilities;

2. Service-connected veterans for nonservice-related disabilities;

3. Veterans who were prisoners of war;

4. Vietnam War veterans exposed to certain herbicides (Agent Orange veterans):

5. Veterans exposed to ionizing radiation (atomic testing veterans);

6. VA pensioners;

7. World War I, Spanish American War, and Mexican border period veterans; and

8. Veterans with income below an eligibility level set at twice the VA pension rate standard, regardless of age. The Department of Medicine and Surgery treats almost 3

million veterans per year; one and a half million are service connected and 1.4 million non-service connected. The total population base for the new means test legislative proposal is 11.04 million veterans. Four million of this 11.04 million base are service connected and 2.9 million are 65 years of age or older.

Question 13.

What is the current status of the implementation of the decentralized ADP program?

Answer 13.

The Administrator has issued revised ADP policy which provides for distribution of authority and responsibility for development of ADP systems. Specifically he has issued a special delegation to the Department of Medicine and Surgery for the Decentralized Health Care Program. A policy which establishes specific acquisition thresholds for office computers has been issued. All the departments and some staff offices have established planning organizations for ADP activities, consistent with the new policy. An agency-wide ADP Users Group has been established to encourage information sharing among all ADP users.

Question 14.

Regarding the decision that DM&S did not in the current fiscal year need over 2,000 of the FTEE that Congress provided funding for in the FY 85 Appropriations Act, please provide copies of all relevant agency documents relating to this decision. Please also describe the occupations involved and the programs and facilities which did not receive all the staffing contemplated in the agency's FY 1985 budget as augmented by the FY 1985 Appropriations Act.

Answer 14.

The 2,000 FTEE reduction (2,092 Jurisdictional FTEE) from the 1985 appropriated level is the result of three things. First, the proposed rescission would reduce employment 133 FTEE. This reduction would be made in motor pool and public affairs. A 9 FTEE reduction in jurisdictional employment reflects a transfer from jurisdictional FTEE to common service FTEE to more accurately reflect field support provided by the Department of Veterans Benefits. The final reduction of 1,950 FTEE reflects the impact of absorbing unfunded supplemental pay requirements totaling $106,695,000 in 1985 in accord with the Government-wide policy requiring Agencies to absorb a minimum of 50% of their pay raise requirements. The attached chart provides an analysis of the Department of Medicine and Surgery 1985 supplemental pay requirements. As the attached exhibit illustrates, the 1985 supplemental pay requirements for the Medical Care appropriation total $179,219,000. The OMB 1986 passback (December 1985) stated that "For 1985, fifty percent of the pay raise has been included in your 1985 allowance for a supplemental of $72,524,000". The fifty percent pay raise referenced in the statement included the civilian (GS), wage board and the increase in the January 1984 pay raise from 3.5 percent to 4 percent. This reduction was made to help constrain the growth of the Federal budget. A high priority was placed upon insuring that the 1985 budgeted workload levels would be achieved. The 1985 current estimate of 1,280,379 patients treated provides for the budgeted hospital patient workload level adjusted for the impact of the Congressional add-on. The staff outpatient visit level of 17,035,000 visits has also been increased to reflect the impact of the Congressional add-on. In addition, the reduction provides a more manageable 1985 employment level in which to bridge to the 1986 employment level of 192,048.

ANALYSIS OF 1985 INCREASED PAY COSTS
Veterans Administration
Department of Medicine & Surgery
(dollars in thousands)

OMB BULLETIN 85-5

Amounts to be paid to other accounts that are not absorbed administratively	Net Absorption			Additional Appropriation Required
	Possible by administrative action	Requiring Congres. action	Total	
...	...	...	...	$111,413
...	...	...	...	8,220
...	...	...	...	25,415
...	...	...	...	7,758
...	...	...	...	5,305
...	...	...	...	19,108
...	...	...	...	2,000
...	...	...	...	3,011
...	...	...	...	76
...	...	...	...	603
...	76	...	76	...
...	46	...	46	...
...	...	...	...	937
...	...	...	...	183
...	14	...	14	...
...	6	...	6	...

ANALYSIS OF 1985 INCREASED PAY COSTS (Cont.) **OMB BULLETIN 85-5**
Veterans Administration
Department of Medicine & Surgery
(dollars in thousands)

Amounts to be paid to other accounts that are not absorbed administratively	Net Absorption			Additional Appropriation Required
	Possible by administrative action	Requiring Congres. action	Total	
...	$349	...	349	...
...	816	...	816	...
...	35	...	35	...
...	349	...	349	115,361
...	816	...	816	8,296
...	...	...	...	26,201
...	125	...	125	7,758
...	52	...	52	5,305
...	...	...	...	19,108
...	...	...	...	2,000

Question 15.

Please expand on your answer to the question Senator DeConcini asked you at the hearing regarding the impact of the OMB-directed reduction in the numbers of GS-11 to GS-15 positions in DM&S. Please describe the general implications of this reduction on the agency's ability to recruit health-care personnel, especially those employed under title 5, and the impact of the reduction of the funding resources available to DM&S. Also please provide specific details about the numbers of positions that will be downgraded in FY 1985 and that are proposed for downgrading in FY 1986, and the decrease in funding associated with the reduction in each fiscal year with breakdowns by occupation and the facilities affected by the reductions.

Answer 15.

Of the total DM&S employment, 31% are Title 5. Of the Title 5 employees at grades 11-15, 68% are involved in direct patient care. It will be difficult to reduce the average grade of these positions as they typically represent the full performance level for the health care professional. Many of our health care professionals function in an independent situation, either by virtue of geography (over 172 medical centers and 226 outpatient clinics) or shift work, are in an "in-charge" situation, and are frequently the only practitioner of their respective discipline in a given area. The Department's difficulties in reducing grade 11-15 positions has been compounded by the additional staff required to implement unit dose drug programs and establish 52 new Veterans Readjustment Counseling Centers. In addition, the Office of Personnel Management (OPM) implemented a new qualification standard for Medical Technologists which redescribed a number of Medical Technologist positions into the grade 11-15 range. Since the Department's baseline date of March 31, 1983, the number of grade 11-15 Pharmacists, Social Workers and Medical Technicians has increased by 344 positions. To meet our reduction goal, these increases will have to be absorbed by other grade 11-15 occupations.

As of December 31, 1984, the Department must reduce 544 positions before September 30, 1985, to achieve its FY 1985 grade 11-15 ceiling of 15,327. In FY 1986, the Department will have to reduce approximately 306 additional Title 5 grade 11-15 positions. A single reduction goal was assigned to each Region, Central Office and Veterans Canteen Service in FY 1985. Regional Directors have primary responsibility for ensuring grade 11-15 position ceilings are met and have the authority to assign reductions to individual facilities. Attachment A shows by Region, Medical District and Facility the grade 11-15 on-board count as of December 31, 1984, and the position ceiling that must be achieved by September 30, 1985.

The Department is expected to achieve these goals through normal personnel turnover. Reorganizations involving reductions-in-force and downgrading of encumbered positions with the express purpose of achieving established reduction goals have been prohibited. The six Regional Directors have indicated that for facilities to meet their grade 11-15 targets, a freeze will have to be imposed on both recruitment and promotion to all Title 5 grade 11-15 positions. Because reductions will be made as vacancies occur, there is no way to project the number of reductions that will be made in each occupation. Recurring budget reductions in DM&S, are identified in Attachment B. Budget reductions will be distributed to facilities in proportion to the position reductions each must absorb.

STATION	TYPE	STATION NO	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION 1					
MEDICAL DISTRICT 1			783	758	25
BEDFORD MASS	[illegible]	[illegible]	111	109	2
BOSTON MASS	[illegible]	[illegible]	146	141	5
BOSTON MASS	[illegible]	[illegible]	71	68	3
	[illegible]	[illegible]	147	145	2
MANCHESTER N H	[illegible]	[illegible]	45	44	1
NORTHAMPTON MASS	[illegible]	[illegible]	76	76	0
PROVIDENCE R I	[illegible]	[illegible]	70	69	1
TOGUS MAINE	[illegible]	[illegible]	78	73	5
WHITE RIVER JCT VT	[illegible]	[illegible]	39	33	6
MEDICAL DISTRICT 2			470	469	1
ALBANY N Y	[illegible]	[illegible]	108	111	+3
BATAVIA N Y	[illegible]	[illegible]	36	38	+2
BATH N Y	[illegible]	[illegible]	33	34	+1
BUFFALO N Y	[illegible]	[illegible]	133	126	7
CANANDAIGUA N Y	[illegible]	[illegible]	85	86	+1
SYRACUSE N Y	[illegible]	[illegible]	75	74	1
MEDICAL DISTRICT 3			1189	1142	47
BRONX N Y	[illegible]	[illegible]	147	150	+3
BROOKLYN N Y	[illegible]	[illegible]	216	205	11
CASTLE POINT N Y	[illegible]	[illegible]	44	43	1
MONTROSE N Y	[illegible]	[illegible]	119	111	8
NEWINGTON CONN	[illegible]	[illegible]	51	50	1
NEW YORK N Y	[illegible]	[illegible]	193	189	4
NORTHPORT N Y	[illegible]	[illegible]	172	155	17
[illegible]	[illegible]	[illegible]	109	106	3
WEST HAVEN CONN	[illegible]	[illegible]	138	133	5
NEW YORK N Y	[illegible]	[illegible]			
NON MEDICAL DISTRICT 20					
[illegible]	[illegible]	[illegible]			
[illegible]	[illegible]	[illegible]			
[illegible]	[illegible]	[illegible]			
WASHINGTON D C	[illegible]	[illegible]			
TOTAL			2442	2369	73

STATION	TYPE	STATION NO	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION II					
MEDICAL DISTRICT 4			736	706	30
COATESVILLE PA	PSY	542	115	108	7
EAST ORANGE N J	GEN	561	179	175	4
LEBANON PA	GEN	595	70	67	3
LYONS N J	PSY	604	109	102	7
PHILADELPHIA PA	GEN	642	137	133	4
WILKES-BARRE PA	GEN	693	80	77	3
WILMINGTON DEL	GEN	460	46	44	2
MEDICAL DISTRICT 5			312	287	25
ALTOONA PA	GEN	503	26	24	2
BUTLER PA	GEN	529	38	37	1
CLARKSBURG W VA	GEN	540	30	30	0
ERIE PA	GEN	562	28	26	2
PITTSBURGH PA (HD)	PSY	645	106	98	8
PITTSBURGH PA (UDiv)	GEN	646	84	72	12
MEDICAL DISTRICT 6			486	456	30
BALTIMORE MD	GEN	512	84	76	8
FT HOWARD MD	GEN	513	43	37	6
MARTINSBURG W VA	GEN DOM	613	77	74	3
PERRY POINT MD	PSY	641	91	92	+1
WASHINGTON D C	GEN	688	191	177	14
MEDICAL DISTRICT 7			456	423	33
BECKLEY W VA	GEN	517	24	22	2
HAMPTON VA	GEN DOM	590	99	93	6
HUNTINGTON W VA	GEN	581	35	32	3
RICHMOND VA	GEN	652	186	169	17
SALEM VA	GEN	658	112	107	5
MEDICAL DISTRICT 8			382	363	19
ASHEVILLE N C	GEN	637	70	66	4
DURHAM N C	GEN	558	96	92	4
FAYETTEVILLE N C	GEN	565	39	37	2
MOUNTAIN HOME TN	GEN DOM	621	87	79	8
SALISBURY N C	PSY	659	90	89	1
TOTAL			2372	2235	137

STATION	TYPE	STATION NO	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION III					
MEDICAL DISTRICT 9			456	453	3
AUGUSTA GA (2 Div)	[illegible]	[illegible]	144	144	0
CHARLESTON S C	[illegible]	[illegible]	52	51	1
COLUMBIA S C	[illegible]	[illegible]	74	81	+7
DECATUR GA	[illegible]	[illegible]	131	125	6
DUBLIN GA	[illegible]	[illegible]	55	52	3
MEDICAL DISTRICT 10			518	492	26
BILOXI MISS (2 Div)	[illegible]	[illegible]	100	101	+1
BIRMINGHAM ALA	[illegible]	[illegible]	109	102	7
JACKSON MISS	[illegible]	[illegible]	97	89	8
MONTGOMERY ALA	[illegible]	[illegible]	31	30	1
TUSCALOOSA ALA	[illegible]	[illegible]	91	88	3
TUSKEGEE ALA	[illegible]	[illegible]	90	82	8
MEDICAL DISTRICT 11			543	525	18
LEXINGTON KY (2 Div)	[illegible]	[illegible]	128	123	5
LOUISVILLE KY	[illegible]	[illegible]	72	68	4
MEMPHIS TN	[illegible]	[illegible]	157	146	11
MURFREESBORO TN	[illegible]	[illegible]	88	94	+6
NASHVILLE TN	[illegible]	[illegible]	98	94	4
MEDICAL DISTRICT 12			661	657	4
BAY PINES FLA	[illegible]	516	173	164	9
GAINESVILLE FLA	[illegible]	573	117	123	+6
LAKE CITY FLA	[illegible]	[illegible]	29	30	+1
MIAMI FLA	[illegible]	[illegible]	188	190	+2
TAMPA FLA	[illegible]	673	154	150	4
MEDICAL DISTRICT 13			515	478	37
ALEXANDRIA LA	[illegible]	[illegible]	45	46	+1
FAYETTEVILLE ARK	[illegible]	[illegible]	32	34	+2
LITTLE ROCK ARK (2 Div)	[illegible]	[illegible]	220	199	21
NEW ORLEANS LA	[illegible]	[illegible]	144	131	13
SHREVEPORT LA	[illegible]	[illegible]	74	68	6
TOTAL			2693	2605	88

STATION	TYPE	STATION NO	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION IV					
MEDICAL DISTRICT 13			572	557	15
CHILLICOTHE OH	NP	[illegible]	90	83	7
CINCINNATI OH	GEN	[illegible]	95	91	4
CLEVELAND OH (2 DIV)	GEN	[illegible]	259	255	4
COLUMBUS OH	OPC	[illegible]	22	22	0
DAYTON OH	GEN DOM	[illegible]	106	106	0
MEDICAL DISTRICT 14			382	366	16
ALLEN PARK MICH	GEN	[illegible]	128	128	0
ANN ARBOR MICH	GEN	[illegible]	108	103	5
BATTLE CREEK MICH	NP	[illegible]	118	110	8
SAGINAW MICH	GEN	[illegible]	28	25	3
MEDICAL DISTRICT 15			329	312	17
DANVILLE ILL	GEN	[illegible]	99	93	6
FT WAYNE IND	GEN	[illegible]	26	27	+1
INDIANAPOLIS IND (2 DIV)	GEN	[illegible]	117	111	6
MARION IND	NP	[illegible]	87	81	6
MEDICAL DISTRICT 16			363	342	21
IRON MOUNTAIN MI	GEN	[illegible]	23	22	1
MADISON WISC	GEN	[illegible]	81	74	7
TOMAH WISC	NP	[illegible]	61	62	+1
[illegible] WISC	GEN	[illegible]	198	184	14
MEDICAL DISTRICT 17			639	634	5
CHICAGO ILL (LS)	GEN	[illegible]	83	81	2
CHICAGO ILL (WS)	GEN	[illegible]	139	144	+5
HINES IL	GEN	[illegible]	260	252	8
NORTH CHICAGO ILL	GEN	[illegible]	157	157	
MEDICAL DISTRICT 21			374	348	26
COLUMBIA MO	GEN	[illegible]	77	64	13
MARION ILL	GEN	[illegible]	31	38	+7
POPLAR BLUFF MO	GEN	[illegible]	23	21	2
ST LOUIS MO (2 DIV)	GEN	[illegible]	243	225	18
TOTAL			2659	2559	100

STATION	TYPE	STATION NO	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION 5					
MEDICAL DISTRICT [illegible]			368	346	22
FARGO N D	GEN	437	39	38	1
MINNEAPOLIS MINN	GEN	618	207	192	15
ST CLOUD MINN	PSY	[illegible]	76	73	3
SIOUX FALLS S D	GEN	[illegible]	46	43	3
MEDICAL DISTRICT [illegible]			967	948	19
BONHAM TEX	GEN DOM	[illegible]	21	19	2
DALLAS TEX	GEN	[illegible]	140	140	0
HOUSTON TEX	GEN	[illegible]	211	204	7
KERRVILLE TEX	GEN	[illegible]	31	31	0
MARLIN TEX	GEN	611	21	18	3
MUSKOGEE OKLA	GEN	[illegible]	52	50	2
OKLAHOMA CITY OKLA	GEN	[illegible]	117	118	+1
SAN ANTONIO TEX	GEN	671	153	152	1
TEMPLE TEX	GEN DOM	[illegible]	107	105	2
WACO TEX	PSY	[illegible]	114	111	3
MEDICAL DISTRICT [illegible]			329	316	13
KANSAS CITY MO	GEN	[illegible]	104	103	1
LEAVENWORTH KS	GEN DOM	[illegible]	82	80	2
TOPEKA KS	GEN	677	94	90	4
WICHITA KS	GEN	[illegible]	49	43	6
MEDICAL DISTRICT [illegible]			419	418	1
DES MOINES IOWA	GEN	[illegible]	62	59	3
FT MEADE S D	PSY	[illegible]	40	41	+1
GRAND ISLAND NE	GEN	[illegible]	16	17	+1
HOT SPRINGS SD	GEN DOM	[illegible]	37	39	+2
IOWA CITY IOWA	GEN	[illegible]	69	68	1
KNOXVILLE IOWA	PSY	[illegible]	68	70	+2
[illegible] NE	GEN	[illegible]	36	35	1
OMAHA NE	GEN	[illegible]	91	89	2
MEDICAL DISTRICT [illegible]			356	349	7
CHEYENNE WYO	GEN	[illegible]	14	14	0
DENVER COLO	GEN	[illegible]	95	93	2
FT HARRISON MONT	GEN	[illegible]	20	20	0
FT LYON COLO	PSY	[illegible]	47	49	+2
GRAND JUNCTION COLO	GEN	[illegible]	20	16	4
MILES CITY MONT	GEN	617	13	13	0
SALT LAKE CITY UTAH	GEN	[illegible]	115	109	6
SHERIDAN WYO	PSY	[illegible]	32	35	+3
TOTAL			2439	2377	62

ATTACHMENT A

STATION	TYPE	STATION ID	ON-DUTY 12/31/84	EOY CEILING 9/30/85	REDUCTIONS BY 9/30/85
REGION VI					
MEDICAL DISTRICT [illegible]			417	399	18
ALBUQUERQUE N M	GEN	[illegible]	103	95	8
AMARILLO TEX	GEN	[illegible]	37	37	0
BIG SPRING TEX	GEN	[illegible]	33	30	3
EL PASO TEX	OPC	[illegible]	20	17	3
PHOENIX ARIZ	GEN	[illegible]	98	89	9
PRESCOTT ARIZ	GEN DOM	[illegible]	39	37	2
TUCSON ARIZ	GEN	[illegible]	87	94	+7
MEDICAL DISTRICT [illegible]			1137	1109	28
LAS VEGAS NEV	OPC	[illegible]	18	18	0
LOMA LINDA CA	GEN	[illegible]	119	115	4
LONG BEACH CA	GEN	[illegible]	268	256	12
LOS ANGELES CA	OPC	[illegible]	53	50	3
SAN DIEGO CA	GEN	[illegible]	144	137	7
SEPULVEDA CA	GEN	[illegible]	190	186	4
WEST LOS ANGELES CA [illegible]	GEN	[illegible]	345	347	+2
MEDICAL DISTRICT [illegible]			666	671	+5
FRESNO CA	GEN	[illegible]	53	54	+1
HONOLULU HAWAII	VARO	[illegible]	19	20	+1
LIVERMORE CA	GEN	[illegible]	36	32	4
MANILA PI	VARO	[illegible]	2	2	0
MARTINEZ CA	GEN	[illegible]	105	100	5
PALO ALTO CA [illegible]	NP GEN	[illegible]	227	227	0
RENO NEV	GEN	[illegible]	57	56	1
SAN FRANCISCO CA	GEN	[illegible]	167	180	+13
MEDICAL DISTRICT [illegible]			534	499	35
AMERICAN LAKE WASH	[illegible]	[illegible]	65	56	9
ANCHORAGE ALASKA	VARO	[illegible]	12	8	4
BOISE IDAHO	GEN	[illegible]	50	46	4
PORTLAND OR [illegible]	GEN	[illegible]	153	138	15
ROSEBURG OR	GEN	[illegible]	43	38	5
SEATTLE WASH	GEN	[illegible]	127	132	+5
SPOKANE WASH	GEN	[illegible]	31	32	+1
WALLA WALLA WASH	GEN	[illegible]	21	21	0
WHITE CITY OR	DOM	[illegible]	32	28	4
TOTAL			2754	2678	76

Attachment B

DM&S
GRADE REDUCTION ANALYSIS (IN 000's)
RECURRING BUDGET CUTS

		FY 85 (.55)	FY 86 (1.65)	FY 87 (2.75)	FY 88 (3.85)	FY 89 (4.40)*	TOTAL (13.20)
GS/GM							
Medical	458,742,137	$2,524	7,570	12,616	17,662	20,186	60,558
Research	33,797,247	186	530	880	1,220	1,400	4,216
MAMOE	17,707,013	97	250	425	680	680	2,132
	TOTAL	2,807	8,350	13,921	19,562	22,266	66,906
TITLE 38							
Medical	964,571,111	$5,305**	-5,305	———	———	———	———
Research	8,359,997	46	———	———	———	———	46
MAMOE	1,085,878	6		———	———	———	6
	TOTAL	5,357	-5,305				52
TOTAL							
Medical	1,423,313,248	7,829	2,265	12,616	17,662	20,186	60,558
Research	2,157,244	232	530	880	1,220	1,400	4,262
MAMOE	18,792,891	103	250	425	680	680	2,138
	TOTAL	8,164	3,045	13,921	19,562	22,266	66,958

*Due to an annualization factor, final savings are realized during the fifth year (1989).

** Budget reductions generated by Title 38 Medical Care positions were for FY 1985 only; monies were restored to the budget in FY 1986.

Question 16.

A. Please describe your understanding of the relationship between the cost to the Federal Government of an episode of care for an individual in the VA as compared to the same care in a non-VA facility reimbursed through Medicare.

B. Please describe your plans, if any, to develop more current, comprehensive data regarding this cost comparison.

Answer 16.

The Veterans Administration has not yet been able to get adequate data to compare full costs of Medicare payments, including Parts A & B, in order to make such a comparative study with Medicare. Such data will soon be available. A study of comparative costs using 1982 reimbursement data from the State of Maryland shows VA costs to be comparable to those of Maryland when adjusted by DRGs for casemix. According to the Health Care Financing Administration (HCFA), the average reimbursement per person served by the Medicare Program in 1984 was $5,174 for inpatient hospital services and $710 for physician services - a total of $5,884. Including the one-day deductible of $356, this would make the average Medicare case $6240. The VA estimates its costs per person hospitalized at $6,003 for 1984, including physician costs. The Medicare cost of $5,884 covers inpatient hospitalization and supplementary medical insurance (Medicare Parts A & B), which includes physician and other medical services. The VA cost estimate of $6,003 is an all inclusive figure that covers inpatient and outpatient care as well as physician costs. It also includes an additional 9% of VA per-person cost for "debt financing" so as to make VA costs more comparable to those of the private sector, which has to pay the cost of borrowing money.

Data are currently being gathered from a variety of states and payers in order to make such a comparison. These sources will include, if available, data on Medicare reimbursement. These studies should be available by September 1985.

Question 17.

With regard to the "one percent productivity increase" which is discussed at page 5-34 of the VA budget documents, please provide as much detail as is available at this time on how the productivity increases will be translated into personnel reductions and indicate, by facility and occupation from which facilities the 1,916 FTEE reduction will be taken.

Answer 17.

The 1986 employment level of 192,048 FTEE will continue to support the patients treated level included in the 1985 budget (about 1,280,000 patients treated). The net result

of a productivity increase is that while average employment decreases, it is not accompanied with a corresponding workload decrease.

1. For the 1,916 FTEE to improve productivity, 32% of this reduction (613) will be assessed to all facilities based on the proportion of their indirect FTEE to all indirect FTEE. Indirect costs and costs not included in the Resource Allocation Models (for acute, ambulatory, and long term care) used for FY 86, average 32% systemwide.

2. The remaining 1,303 will be assessed to medical centers based on their relative efficiency as measured by methods derived from the Resource Allocation Models (RAMs). Under this method only facilities whose efficiency per direct care FTEE is below the system norms developed from the RAMs will be reduced on a proportionate basis. This will be applied to the 68% of facility costs that are direct medical care as measured by the RAMs.

3. All facilities will have some FTEE reduction calculated for their indirect costs and costs not measured by the RAMs, and some facilities will have FTEE reductions assigned to the direct services measured by the RAMs. However, the net reduction or

gain in FTEE will not be assigned to any specific category and the facility directors will make the decision as to how the FTEE change should be spread.

4. Specific facility reductions are not available at this time, nor are the specific occupation reductions known.

5. In line with the Administration's management initiatives, we are planning to conduct most efficient organization (MEO) reviews and expect that productivity improvements will be identified and pursued.

Question 18.

A. Dr. Ditzler, with respect to your interest in enhancing the Department's quality assurance efforts, please describe your plans in this regard.

B. To the extent you will need additional resources to carry out such plans, please indicate the numbers, types, and probable duty stations of the personnel you would utilize in such a quality assurance effort and the overall cost of such effort.

Answer 18.

A. The primary initiative for improvement of the Department's quality assurance efforts will be the incorporation of a district review component. Currently quality assurance activities are carried out at each facility through the Health Services Review Organization - Systematic Internal Review (HSRO-SIR) program; and external review of each facility is carried out through the HSRO -

Systematic External Review Program (HSRO-SERP). In addition to these quality assurance activities, a component will be added to the HSRO program which will require each Medical District, with oversight by each Regional Director, to perform ongoing monitors of the quality and appropriateness of care. This component of HSRO will be called Medical District Initiated Peer Review Organization (MEDIPRO), and will meet the intent of the PRO legislation in the non-government sector, as well as focusing on the quality of care. The program is being developed now, will be pilot tested at two medical districts and implemented in all districts in FY 1986.

B. No Additional staffing and travel dollars are requested in FY 1986 for the pilot tests and for full implementation for field facilities and VACO. Full implementation is scheduled to begin approximately April 1986.

a. Field resource needs for the pilot: The pilot tests will be conducted in two medical districts from September 1985 through March 1986, and will require a total of 4 FTEE and approximately $20,000 in travel dollars in FY 1986. There will be 2 FTEE located at Medical District 17 (Chicago) and 2 FTEE located at Medical District 9 (Atlanta). Each district will have one PRO

Coordinator, and one Clinical Evaluator, both of whom will have clinical knowledge about patient care and be skilled in quality assurance and data analysis. Total salary costs for these four staff for FY 1986 are estimated at $140,000.

b. Field resource needs for full implementation: Full implementation of the MEDIPRO in all districts will require 52 additional FTEE, and approximately $ 350,000 additional in travel dollars for Medical District use. (These estimates exclude the FTEE and travel monies discussed above for the pilots). The FTEE will include a PRO Coordinator and a Clinical Evaluator located at each Medical District office, requiring approximately $930,000 in salary dollars in FY 1986. These salary dollars are projected for 6 months of full implementation in FY 1986.

c. VACO costs: During the pilot test and full implementation approximately $150,000 additional travel dollars will be needed in VACO to support task forces, and field details for MEDIPRO developmental, and evaluation activities. Three additional FTEE for VACO are needed during the pilot test and for full implementation; this will require approximately $105,000 salary dollars for staff knowledgeable about patient care processes and skilled in quality assurance and data analysis. Finally, approximately $100,000 in consultant funds will be required.

d. Annual operating costs for FY 1987 and beyond: Results of the Pilot tests will influence resource needs and projections. The best estimate at this time is that annually, $2,000,000 in field salaries (for 56 FTEE of the type described above, 2 per Medical District) will be required, and $750,000 travel dollars for the Medical District Staff will be required. VACO staff of 3 FTEE will require approximately $105,000 in salary dollars, and VACO travel dollars of approximately $150,000 will be needed annually to conduct evaluation of the PRO program, and provide program direction and coordination. VACO will also require $100,000 in consultant fees annually. The total program costs will be approximately $3 million dollars.

Question 19.

A. Please describe the effect under each VA appropriations account involved if the VA were forced to absorb the amounts by which the budget request for it has been reduced on the basis of the Administration's proposed legislation to make an across-the-board 5-percent cut in Federal employees' pay.

B. Dr. Ditzler, could you describe the likely impact on DM&S of absorbing a further cut of $202.1 million if the 5-percent pay cut is not enacted?

C.(i) Dr. Ditzler, what is your view of the current effect on morale in DM&S of the proposal for a 5-percent pay cut?

(ii) What is your estimate of what the actual effect on morale would be if such a cut were implemented?

Answer 19.

A. **Below is a discussion of the impact on each appropriation of absorbing the five percent payroll reduction:**

MEDICAL CARE - The Medical Care appropriation is primarily a workload generated program. That is, it is not possible to absorb requirements in either payroll or non-payroll accounts without impacting workload (patients treated and outpatient visits) at VA facilities. If it is necessary to absorb the $202,974,000 attributed to the five percent pay reduction, it will be necessary to reduce employment 5,024 FTEE and would result in a decrease of 42,700 patients treated and 192,000 outpatient visits.

RESEARCH - In the Medical and Prosthetic Research appropriation, the impact of the proposed five percent pay reduction ($4,287,000) would result in a decrease of 73 programs and 114 FTEE. This would result in support for only the highest priority ongoing programs.

The rehabilitation research activity would result in a reduction of 3 projects and 5 FTEE. This would impair the ability to transfer technology to meet the needs of the disabled.

Absorption of the five percent reduction would necessitate the cancellation of 2 health services research and development investigator-initiated projects and a reduction of 3 FTEE.

MAMOE - If the five percent payroll reduction ($1,240,000) is not restored, a further reduction of 27 FTEE would be made, as there are no resources available to reprogram to meet payroll requirements.

GENERAL OPERATING EXPENSES - For the GOE appropriation, a reduction of 664 FTEE would be necessary to generate sufficient savings to absorb the $18,838,000 if the subject legislation did not pass and funds were not restored. This would require a total of 1,499 FTEE cut (-7.7%) in GOE. The estimate is based on the assumption that employment reductions could be met through normal attrition, the least costly employment reduction alternative.

OFFICE OF CONSTRUCTION - The Office of Construction's operating costs are funded from the construction, minor appropriation. If forced to absorb the amounts by which the budget request has been reduced due to the proposed 5 percent cut in Federal employees pay, the Office of Construction will request a reprogramming of funds available in the minor working reserve, and an increase of $1,007,000 in the General Administration limitation. This reserve has sufficient funds to cover the restoration of the pay cut. Should the reprogramming not be approved, all support services

would be eliminated and further FTE reductions would be necessary.

B. **An absorption of $203 million in the Medical Care appropriation would result in an employment reduction of 5,024 FTEE from the requested level of 192,048. This would result in workload reductions of 42,700 patients treated and 192,000 outpatient visits from the 1986 request level.**

C. My personal view is that the current effect of the proposal for a 5 percent pay cut on morale is sobering. The VA employs many fine, responsible individuals who strive for excellence in job performance. They value their jobs and the service they are able to provide to America's veterans. In return, they have expectations for a sense of job security and recognition for work well done, so there would be a negative impact on morale.

It is possible that we could experience the departure of some of our more critical heatlh care personnel, e.g., nurses, pharmacists, and physical therapists, who are clearly in salary-sensitive occupations and who enjoy viable employment options outside the VA. It is possible that some losses to the VA system will be offset by individuals from the private sector who have experienced the results of cut-backs as private hospitals adjust to a DRG-based reimbursement system.

Question 20.

A. Please indicate what resources, both in terms of FTEE and dollars, DMGS devoted in fiscal year 1984 and you plan to devote in each of fiscal years 1985 and 1986, to the following activities:
(i) Hospital-based home care programs.
(ii) Geriatric Research, Education, and Clinical Centers.
(iii) Geriatric evaluation units.
(iv) Adult day health care services.
(v) Hospice programs.
(vi) Programs to coordinate VA programs with appropriate community programs.

B. What efforts are ongoing or planned for either fiscal year 1985 or 1986 to evaluate the cost-effectiveness of HBHC programs, GEUs, ADHC programs, respite care, and any other programs designed to meet the needs of older veterans in non-institutional settings?

Answer 20.

A.

Hospital Based Home Care

Medical Care
Hospital Based Home Care
(dollars in thousands)

	1984	1985	1986	Change
Budget Authority	$ 12,974	$ 14,739	$ 15,271	$+ 532
FTEE	370	400	414	+ 14
Teams	43	49	49	...
Home Visits	199,000	203,258	204,938	+ 1,680
ADC	2,668	2,878	2,998	+ 120

The above chart provides the latest estimate of resources and workloads associated with the Hospital Based Home Care (HBHC) Program. In addition to adding 12 teams in 1984, a new HBHC Program was activated in Tampa, and the Little Rock program was enhanced. The 1985 budget includes resources for 6 additional teams. The 1986 increase of $532,000 and 14 FTEE reflects: annualization of the 1985 increase ($708,000 and 18 FTEE); uncontrollable increases to the program ($394,000 for within grades, pay annualization, and inflation); offset by the 5 percent pay reduction ($450,000 in 1986) and 1 percent productivity increase (reduction of $120,000 and 4 FTEE).

Geriatric Research, Education, and Clinical Centers (GRECCs)

1.

GRECCs
(dollars in thousands)

	1984		1985		1986		Change	
	B.A.	FTEE	B.A.	FTEE	B.A.	FTEE	B.A.	FTEE
Medical Care	$ 6,029	127	$10,769	171	$ 9,547	169	$-1,222	-2
MAMOE	340	2	362	2	375	2	+ 13	...
Research	2,056	57	2,150	62	2,050	60	- 100	-2
Total	$ 8,425	186	$13,281	235	$11,972	231	$-1,309	-4
No. of GRECCs	10		10		10		...	

The above chart provides the latest estimates of resources associated with the GRECC Program. In 1986, $9,547,000 and 169 FTEE (Medical Care appropriation) will continue to support the 10 established GRECCs. The reduction of $1,222,000 and 2 FTEE in Medical Care from the 1985 estimate reflects: a reduction in one time capital investment, and maintenance and repair costs associated with fully funding two GRECCs in 1985 (reduction of $1,079,000); the government-wide pay reduction and productivity increase (reduction of $398,000 and 2 FTEE); offset by uncontrollable increases for inflation and within grades ($255,000).

Geriatric Evaluation Units

Medical Care
Geriatric Evaluation Units
(dollars in thousands)

	1984*	1985	1986	Change
Budget Authority	...	$1,324	$1,301	$ -23
FTEE	...	34	34	...
Units	39	40	40	...

*In FY 1984 there was no specific budget authority for GEUs. VA medical centers operated 39 GEUs using available FTEE and funds provided for VA hospital operations. FTEE assigned and costs distributed were not separately identified for GEUs.

Additional resources from the FY 1985 Congressional add-on have been distributed to VA medical centers to provide two additional staff for each of 17 existing Geriatric Evaluation Units. The resources (dollars and FTEE) listed above reflect additional funding of these existing 17 GEUs.

In FY 1986 the VA will continue the operation of existing Geriatric Evaluation Units. Activation of any new GEUs at this time will be through redesignation of beds and program activities, with reprogramming of existing resources as appropriate. The reduction of $23,000 in 1986 reflects the government-wide 5 percent pay reduction (-$49,000) offset by uncontrollable payroll increases for normal salary increases and annualization of the January 1985 pay raise ($26,000).

Adult Day Health Care

Medical Care
Adult Day Health Care
(dollars in thousands)

	1984*	1985	1986	Change
Budget Authority	...	$1,376	$1,386	$ +10
FTEE	...	34	34	...
Centers	4	9	9	...

*In FY 1984 there was no specific budget authority for ADHCs. VA medical centers operated 4 ADHCs using available FTEE and funds provided for VA hospital operations. FTEE assigned and costs distributed were not separately identified for ADHCs.

Additional resources from the FY 1985 Congressional add-on are being used to provide for 4 ADHCs located at VA Medical Centers Little Rock, Arkansas; Miami, Florida; Minneapolis, Minnesota; and Portland, Oregon. The resources listed above reflect funding requirements for these four centers. Activation of these ADHCs will result in a total of 9 ADHCs in operation. The 5 other ADHCs were funded from available resources, 4 prior to FY 1984 and 1 in FY 1985.

In FY 1986 the VA will continue the operation of existing ADHCs and begin studying the medical efficacy and cost effectiveness of this program. An additional $10,000 will be required to support the 4 newly established centers in 1986. A $35,000 reduction resulting from the government-wide 5 percent pay cut is offset by uncontrollable increases in payroll ($18,000) and the inflationary impact on non-payroll items ($27,000).

Hospice Programs

There is only one Central Office funded Hospice Program which is located at the West Los Angeles (Wadsworth) Medical Center. All other hospice activities are supported by VA medical centers from VA hospital operations resources, and FTEE and costs distributed are not reported separately. The estimated resources for the Wadsworth VA Medical Center Palliative Treatment Program are reflected in the following chart.

Palliative Treatment Program
(dollars in thousands)

	1984*	1985	1986	Change
Cost	716	$ 750	$ 743	$ -7
FTEE	20.5	20.5	20.5	...
Days of Care				
Inpatient	3,229	3,230	3,262	32
Home	8,914	8,915	9,004	89

The reduction of $7,000 from the 1985 estimate reflects: the government-wide pay reduction (reduction of $25,000); offset by uncontrollable increases for inflation ($5,000) and within grades ($13,000).

Programs to coordinate VA programs with appropriate community programs. The VA is involved in many significant ways in coordinating with appropriate community programs on a continuing basis. For example, as a part of MEDIPP, Medical Districts must assure that in their planning efforts opportunities for cooperation are identified and fully developed. In planning for patient discharge, such opportunities are explored and utilized for the placement of patients. The VA also provides information and referral services for older people in participation with 15 Federal departments and agencies. The costs of these and other similar activities are not separately identified from VA hospital operation costs. Any estimate of FTEE and dollars would be very subjective.

B. The Department continues to assess the efficacy of the medical and health related programs. Evaluations of the benefits and effectiveness compared to the cost of other programs continue and currently demonstrate some promising results.

HBHC is a significant alternative to long term care institutionalization in a nursing home. Various studies of home health care programs have been showing positive cost benefits while the definitive answers to cost effectiveness have yet to be concluded.

Studies of GEUs within and outside the VA have demonstrated certain values to this modality of comprehensive assessment of the elderly patient. One study conducted at the VA GRECC at Sepulveda has been reported on in a special article in The New England Journal of Medicine, December 27, 1984. The article entitled "The Effectiveness of a Geriatric Evaluation Unit" described a randomized clinical trial of assigning frail elderly inpatients with a high probability of nursing home placement to a GEU. It was concluded that GEUs can provide substantial benefits at minimal cost for appropriate groups of elderly patients, over and above the benefits of traditional hospital approaches. More work needs to be done in order to be completely certain of their cost effectiveness.

ADHC is considered to be another alternative to long term institutionalization in a nursing home. ADHC is in the early stages of development and when additional programs are activated it will be possible to conduct the health services research study required by Public Law 98-160.

No studies have been conducted to evaluate the cost effectiveness of respite care. The VA has not established respite care as a program. Until such time as a program is established, the VA does not plan to conduct a study.

The GRECCs have been the subject of several evaluations and are currently under assessment by the Office of Policy, Planning and Evaluation (07). The GRECCs have already demonstrated their value as centers of excellence consistent with the mandates in the law. Annual reports demonstrate preliminary positive findings as to their cost effectiveness.

Management Information Systems and "national" evaluation strategies for all these programs are in process and, hence, more definitive data will be available in the near future. This information will be critical to more definitive analyses of efficacy and the usefulness of these programs.

Question 21.

A. Please provide information showing the levels of the medical care, medical and prosthetic research, MAMOE, and construction budget, separately, expressed in FY 1975 constant dollars through the use of appropriate deflators, for each year beginning with FY 1975 through the level proposed for FY 1986.

B. Please provide the same information, using FY 1970 constant dollars, for each year since FY 1970.

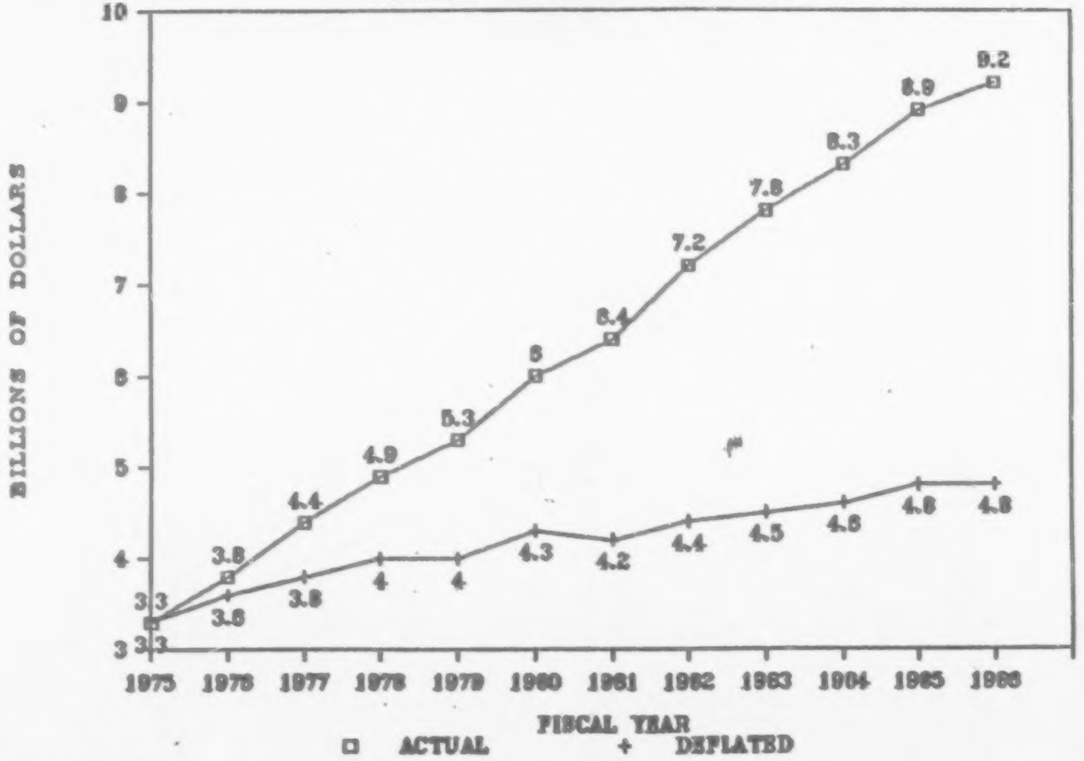
Answer 21.

A. The following charts provide a graphic illustration of the actual dollars (estimated FY 1985 & FY 1986) and the adjusted (deflated) dollars for the requested appropriations.

B. The following charts provide adjusted resources (estimated FY 1985 & FY 1986) in FY 1970 dollars.

MEDICAL CARE

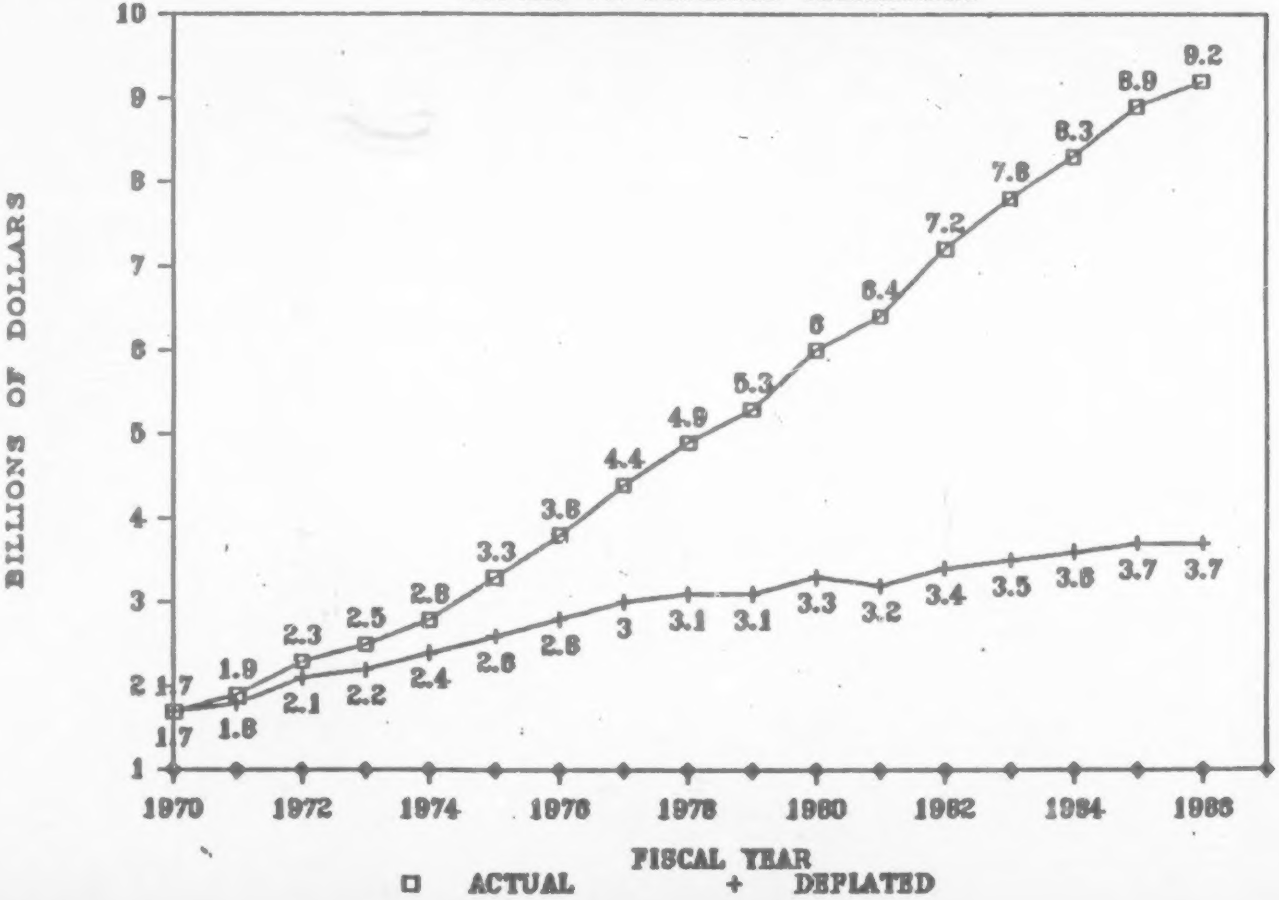
ACTUAL VS. DEFLATED OBLIGATIONS



21.A.

MEDICAL CARE

ACTUAL VS. DEFLATED OBLIGATIONS



Question 22.

A. Please provide information illustrating the per diem cost to the Federal Government (including Medicaid costs, as such information is available) of providing a veteran nursing home care in (i) a VA nursing home, (ii) a State Veterans' Home Nursing Home, and (iii) a community nursing home.

B. Please provide similar illustrative information for the per diem cost to a State government (again including Medicaid costs, as available) of providing a veteran such care in (i) a State Veterans' Home Nursing Home and (ii) a community nursing home.

C. If possible, please make overall cost comparisons between the types of facilities specified in parts A and B, taking into account the VA contribution to construction costs.

Answer 22.

A. The average per diem costs to the VA for 1984 for providing veteran nursing home care were:

VA Nursing Home Care Units (VA NHCU)	$ 107.84
State Veterans' Home Nursing Home (1st half year, $12.10; 2nd half, $17.05)	$ 14.60
Community Nursing Home Care (CNHC) Facilities	
Average Per Diem Paid	$ 55.19
VA Support	$ 4.50
	$ 59.69

The VA does not obtain information from the States on the amount of Medicaid payments for the care of veterans in State Homes. The National Association of State Veterans Homes, in response to House Veterans Affairs Committee request for information, reported that for the period July 1, 1980 to June 30, 1981, of 47 State Homes surveyed five of six certified homes received Medicaid payments and seven of eight certified homes received Medicare payments (Committee on Veterans' Affairs, House of Representatives, Serial No. 97-36, page 65). As amended by P.L. 98-160, effective April 1, 1984, the VA pays each State at the per diem rate of $17.05 for nursing home care but in no case do the payments exceed one-half of the cost of the veteran's care.

B. The average per diem cost for 40 State Veterans' Home nursing homes in 28 States for 1984 was $60.84. The VA does not have information on the per diem cost to a State government for providing a veteran care in a community nursing home or if any State pays for such care as a veteran benefit.

C. Historically the average per diem cost nationwide of operating a VA NHC Unit has been higher than State homes or contracting for CNHC. One of the reasons is that the costs used to compute the average per diems have different bases. The VA nursing home care total cost is the summation of personnel and other costs incurred at those VA medical centers with nursing home care units. These costs have been distributed from organizational cost centers (i.e., medicine, radiology, etc.) to bed sections (i.e., medical, surgical, nursing home, etc.) based on estimates of usage of personnel time and other services rather than on the basis of individual patient charges for services received. The collocation of the VA nursing home with a hospital and the methodology for distributing all medical center costs may inflate the cost of VA nursing home care. Conversely, the community nursing home care cost is the summation of payments for care based upon negotiated rates for basic nursing home care services. These rates are operationally controlled so as not to exceed the legislative limitation. Because of these limitations the average per diem cost to the VA is most likely less than the national average per diem cost for all community nursing home facilities, and is slightly higher than Medicaid rates.

Another reason for the differences in per diem cost is that the services provided in VA facilities are not the same as those which the VA contracts with community facilities to provide to a potential veteran placement. VA facilities provide a full range of services, without exclusion, to meet the varying needs of all veterans for nursing home care. Many patients need, and receive, much more intensive nursing care services than the typical nursing home care patient. For instance, they require and receive specialized therapies and other services available at a medical center. On the other hand, VA contracts for basic nursing care services from community facilities for a negotiated rate. Community facilities generally will not provide a full range of services, such as occupational and physical therapy or expensive medications, to meet the needs of all veterans for nursing home care at a rate the VA is disposed to pay. Therefore, community nursing homes will not accept all patients that the VA proposes for placement, and usually exclude those requiring more than moderate patient care services. If more than routine services are required by a particular patient, the cost of such services, while paid for separately or provided directly by the VA, are not reflected in the community nursing home care rate.

A third reason for the difference is that VA Nursing Home Care Units have a higher level of nursing staffing than community nursing home care facilities. Nurses in VA Nursing Home Care Units also receive higher average salaries than nurses in community nursing home care facilities due to a greater reliance on RNs rather than nursing aides. An additional staffing cost in the VA Nursing Home Care Units is the reliance on appropriately trained clinical dietitians, dietetic technicians, and food service workers.

Question 23.

With reference to the VA physical fitness program for disabled/handicapped persons as described at page 5-20 of the VA budget doccuments:

A. Please describe in greater detail the elements of this program with particular emphasis on which types of veterans (with breakdowns by age, disability, and percentages of service connection) will be sought to participate in the program, what specific types of programs will be instituted, what the duration of participation in such programs will be for individual veterans, and whether participation will be mandatory or voluntary.

B. Please provide a listing of the medical centers that will participate in this program during FY 1986.

C. What will be the GS-level (or title 38 equivalent) and qualifications of the 17 fitness specialists mentioned in the budget documents?

D.(i) Who at the Central Office level will coordinate this program?

(ii) To whom will this person report?

(iii) What will be this person's GS-grade level and qualifications?

E. Will the program be open to VA employees? If so, please provide details on this aspect.

F. Are there plans to expand this program beyond the medical centers that will receive resources in FY 1986 and, if so, what is the extent of, costs entailed, and timetable for such expansion?

Answer 23.

A. The program design is for the spinal cord injured and orthopedically handicapped patients. There were 60,217 service connected disabilities due to loss of limbs or loss of use of limbs in 1983.

The Spinal Cord Injury Units served an average of 7,800 inpatients yearly. Forty percent (40%) are service connected, 60% nonservice connected; 93.7% are males, 6.3% females, age range from less than 25 - 85 or older.

Fitness and Sports programs will include the summer games that have swimming, archery, track/field events, shotput, discus, javelin, club, tennis, road racing, marathons, etc.

Winter/fall games will include sled skiing, ice hockey, skiing with outriggers, hunting, basketball, bowling, etc. Water Sports - fishing, boating, sailing are examples of activities offered.

The program will be a clinical based program. Each patient will be encouraged to explore new physical activities to determine their area of interest and physical capability as long as they are at the medical center. Furthermore, the patients will have the opportunity to develop a skill level in their chosen activity to the level it is self satisfying.

B. Augusts, GA; Brockton, MA; Palo Alto, CA; Richmond, VA; Wood, WI; Cleveland, OH; Bronx, NY; Hines, IL; East Orange, NJ; Hampton, VA; Miami, FL; Memphis, TN; San Juan, PR; St. Louis, MO; Tampa, FL; West Roxbury, MA, and Castle Point, NY.

C. Office of Personnel Management
GS-638, Recreation Therapist, 9-3 level.

D. (i) Director, Recreation Service

(ii)Assistant Chief Medical Director
for Professional Services.

(iii)GS-14 - Administrator/Master Therapist

E. A pilot program has been established in Central Office to evaluate the potential for field placement.

F. The outyear budget estimates do not include any resources for the further expansion of the physical fitness program. As the success of the program is demonstrated, further expansion of the program will be considered.

Question 24.

At page 5-3 of the budget documents, the medical care account appropriation language is proposed to make up to $5 million available in FY 1986 to fund OMB Circular A-76 cost-comparison studies.

A (i). What was the actual expenditure level for such studies in FY 1984?

(ii). What is the level proposed for fiscal year 1985?

(iii). What is the level proposed for FY 1986?

B. Please provide a listing of all such A-76 studies carried out in FY 1984 and FY 1985 to date and proposed to be carried out during the remainder of this fiscal year and in FY 1986.

C. Please provide a listing of all activities at VA health-care facilities that were contracted out to private firms during FY 1984 or the current fiscal year and the actual cost saving resulting from each such contractor-performed activity.

Answer 24.

A(i). No studies have been completed in DM&S to date.

(ii). The limitation for FY 1985 is still the $2 million level.

(iii). We propose to accelerate this program in 1986 and we estimate that up to $5 million may be expended on such studies

B. The listing is attached. It should be noted that this is a draft plan and subject to change.

C. As stated previously, the Department of Medicine and Surgery has not begun to study activities for possible contracting out, but we plan to initiate such studies in FY 1985. We anticipate these studies to continue for several years, and we are today uncertain about

VA savings to be derived from such contracting out. However, we are informed that the Department of Defense currently reports average cost reductions of 29% resulting from cost effective contracting and in-house efficiencies as an outcome of A-76 studies in 1984.

1. The attached A-76 reports, presented by VA Region and Function, indicate the number of Full Time Equivalent Employees (FTEEs) involved (in the reduction) and the anticipated cost transfer (of salaries) if the function are to be accomplished outside of the Veterans Administration. The following are explanations of the assumptions used in developing these data:

a. Salaries (including fringes) were calculated as follows:

(1)	Chauffeurs	$19,000/Average Annual Salary Per FTEE
(2)	Data/Keypunch	$17,410/Average Annual Salary Per FTEE
(3)	Design/Drafting	$19,000/Average Annual Salary Per FTEE
(4)	Fire Protection	$20,900/Average Annual Salary Per FTEE
(5)	Furniture Repair	$19,000/Average Annual Salary Per FTEE
(6)	Interior Design	$17,410/Average Annual Salary Per FTEE
(7)	Grounds	$19,000/Average Annual Salary Per FTEE
(8)	Laundry	$19,000/Average Annual Salary Per FTEE
(9)	Mail-Messenger	$17,410/Average Annual Salary Per FTEE
(10)	Print/Reproduction	$17,410/Average Annual Salary Per FTEE
(11)	Switchboard	$17,410/Average Annual Salary Per FTEE
(12)	Transcription	$17,410/Average Annual Salary Per FTEE
(13)	VCS Food	$19,000/Average Annual Salary Per FTEE
(14)	Warehouse	$19,000/Average Annual Salary Per FTEE

b. All costs presented are salary/fringe costs only - assuming that contracts will be based on GOCO.

c. Projections are based upon studies beginning in April, 1985 and completed by September 30, 1987.

d. Data have been provided for a total transfer of costs (FTEEs and salaries) if the functions are to be completely accomplished outside of the Veterans Administration. However, these data have also been presented at 25%, 50%, and 75% - to provide projections (of cost transfer) for gradual implementation of outside contracting. Funding would still be required for the commercial activities studied.

e. Savings would be the result of:
   - lower contract costs from previous in-house costs;
   - lower governmental costs as a result of management changes made as a result of the government efficiency studies.

f. Personnel displaced as a result of A-76 and MEO studies would be managed through attrition or placed in other services.

Question 25.

With regard to VA Nursing Home Care Units, please provide a list showing, for FY 1984 and each of the prior four fiscal years, the occupancy rates, waiting lists, and average time on a waiting list for each such unit in operation during that period

Answer 25.

Two lists are provided for VA Nursing Home Care Units for the period 1980-1984; one for "Bed Occupancy Rates" in percent, and the other for "Number of Veterans on the Waiting List" at the end of the year. Average time on a waiting list is not available, since these data are not included in any reporting system.

Bed Occupancy Rates (%)

Facility	1980	1981	1982	1983	1984
Albany, NY	103.0	93.1	94.0	95.0	96.0
Albuquerque, NM	95.7	90.9	93.2	93.5	91.5
Alexandria, LA	86.0	93.5	91.4	93.5	93.5
Allen Park, MI	97.2	98.6	97.2	97.2	95.8
Altoona, PA	90.9	97.0	90.9	97.0	97.0
American Lake, WA	94.7	94.7	96.1	92.1	86.8
Ann Arbor, MI	-	-	-	-	42.9
Asheville, NC	92.7	96.3	95.1	97.6	96.3
Atlanta, GA	-	-	-	-	38.5
Augusta, GA	92.5	95.0	92.5	85.0	87.5
Batavia, NY	-	-	-	-	85.7
Bath, NY	85.6	89.5	92.2	94.6	98.2
Battle Creek, NY	94.1	96.1	96.1	97.1	96.6
Bay Pines, FL	96.7	80.8	93.8	94.6	93.3
Beckley, WV	92.5	95.2	97.6	95.2	97.6
Bedford, MA	95.7	95.7	96.3	96.3	95.7
Big Spring, TX	100.0	100.0	100.0	92.5	97.5
Biloxi, MS	97.1	97.1	97.1	94.3	82.9
Bonham, TX	97.0	97.0	98.0	95.0	97.0
Brockton, MA	96.0	94.0	93.9	92.8	96.0
Brooklyn, NY	97.0	96.3	96.7	95.7	96.0
Buffalo, NY	100.0	97.2	97.2	106.1	97.2
Butler, PA	94.2	92.3	91.3	91.3	92.3
Canandaigua, NY	98.0	99.0	96.7	95.0	95.0
Castle Point, NY	96.6	95.7	95.5	95.3	95.9
Cheyenne, NY	97.9	95.7	93.6	93.6	93.6
Chillicothe, OH	96.0	97.0	98.0	99.0	99.0
Cincinnati, OH	87.9	93.7	93.2	91.3	87.9
Cleveland, OH	97.0	96.0	93.5	94.0	91.0
Coatesville, PA	96.0	104.3	96.0	96.0	78.8

Facility	Bed Occupancy Rates (%)				
	1980	1981	1982	1983	1984
Columbia, MO	96.3	96.3	96.3	96.3	96.3
Columbia, SC	96.1	98.3	95.8	92.5	94.2
Danville, IL	95.0	95.0	95.0	96.7	95.0
Dayton, OH	95.8	94.4	96.1	95.1	95.4
Dublin, GA	94.2	94.2	93.0	94.2	93.0
East Orange, NJ	97.6	96.7	96.7	93.3	95.0
Erie, PA	95.0	92.5	95.0	92.5	95.0
Fargo, ND	85.2	97.8	80.9	89.6	92.0
Fayetteville, NC	97.4	94.9	94.9	94.7	97.2
Fort Howard, MD	93.6	95.7	95.7	95.7	95.7
Fort Lyon, CO	94.6	94.6	94.6	97.3	97.3
Fort Wayne, IN	96.3	94.4	94.4	94.4	96.3
Gainesville, FL	-	-	57.8	94.2	94.2
Grand Island, NE	88.1	90.5	94.9	85.7	81.0
Grand Junction, CO	95.2	92.9	95.2	95.2	97.6
Hampton, VA	75.9	88.3	94.2	87.5	94.2
Hines, IL	-	-	-	53.2	87.5
Houston, TX	96.2	96.2	96.2	94.9	97.4
Indianapolis, IN	95.0	96.7	94.5	93.3	96.4
Iron Mountain, MI	95.0	92.5	92.5	92.5	95.0
Jackson, MS	94.2	93.3	95.0	95.0	95.0
Kerrville, TX	94.3	97.1	94.3	97.1	97.1
Knoxville, IA	97.0	96.4	96.5	95.5	96.5
Lake City, FL	95.0	95.0	95.0	92.5	95.0
Leavenworth, KS	95.6	93.3	95.6	93.3	95.6
Lebanon, PA	98.3	97.5	97.5	97.5	94.2
Lexington, KY	98.0	97.0	98.0	97.0	98.0
Little Rock, AR	96.0	96.0	95.0	94.5	93.5
Livermore, PA	-	-	63.6	88.3	86.7
Loma Linda, CA	93.3	95.0	95.0	95.0	96.7
Long Beach, CA	94.4	93.3	93.9	96.1	96.7
Lyons, NJ	97.8	97.8	96.7	96.7	98.9
Manchester, NH	95.8	93.3	96.7	92.5	90.8
Marion, IN	95.7	97.1	95.7	95.7	94.2
Martinsburg, WV	-	96.4	98.3	98.3	98.3
Memphis, TN	-	27.7	65.0	95.0	94.2
Miami, FL	84.5	80.0	76.6	88.3	90.0
Miles City, MT	104.2	96.2	104.2	96.2	104.2
Montrose, NY	94.3	93.4	94.3	93.4	92.6
Mountain Home, TN	94.8	93.1	93.1	94.8	94.8
Murfreesboro, TN	97.9	97.9	97.9	97.9	97.9
North Chicago, IL	94.2	96.3	96.8	96.3	97.4
Northampton, MA	96.0	96.0	54.4	96.0	98.0
Palo Alto, CA	92.7	94.7	94.7	96.0	95.3
Perry Point, MD	95.0	93.8	93.8	95.0	95.0
Phoenix, AZ	93.3	95.0	94.2	95.0	94.2

Facility	Bed Occupancy Rates (%) 1980	1981	1982	1983	1984
Pittsburgh/Univ Dr, PA	93.4	93.4	98.1	93.4	94.3
Poplar Bluff, MO	95.9	91.8	89.8	91.8	91.8
Portland, OR	-	-	-	-	74.1
Reno, NV	95.5	95.5	95.5	95.5	57.9
Richmond, VA	-	-	-	-	56.9
Roseburg, OR	96.0	97.3	97.3	97.3	98.7
Saginaw, MI	-	83.3	86.7	93.3	96.7
Salem, VA	96.0	96.0	93.0	92.0	92.0
Salisbury, NC	96.8	97.8	96.5	96.8	97.8
Salt Lake City, UT	87.0	75.0	-	-	-
San Diego, CA	91.7	87.9	91.4	91.7	91.7
Sepulveda, CA	81.0	88.0	90.2	93.0	94.8
Sioux Falls, SD	96.0	94.7	93.3	96.0	94.7
St. Cloud, MN	95.5	93.2	95.5	93.2	86.4
St. Louis, MO	96.8	96.8	96.8	97.8	97.8
Syracuse, NY	91.9	84.2	88.0	94.0	92.0
Temple, TX	-	37.1	79.6	94.9	92.5
Togus, ME	96.7	98.3	96.7	95.0	94.5
Tomah, WI	97.0	97.0	97.0	96.0	95.0
Topeka, KS	93.7	92.4	93.2	93.7	94.9
Tucson, AZ	95.1	95.1	92.7	95.1	95.1
Tuscaloosa, AL	94.2	94.2	93.3	95.8	95.0
Tuskegee, AL	95.5	95.5	94.6	94.6	95.5
Waco, TX	98.8	97.6	97.6	97.6	97.6
West Haven, CT	97.8	97.8	96.7	97.8	93.3
White River Jct, VT	96.7	96.7	96.7	93.3	90.0
Wichita, KS	-	-	-	-	71.4
Wilkes-Barre, PA	-	-	28.6	85.8	95.0
Wilmington, DE	95.0	93.3	93.3	93.3	76.7
Wood, WI	97.5	96.0	96.0	96.0	93.5

	Number of Veterans on the Waiting List				
Facility	1980*	1981	1982	1983	1984
Albany, NY		24	13	17	9
Albuquerque, NM		-	-	5	1
Alexandria, LA		14	9	6	8
Allen Park, MI		-	-	1	1
Altoona, PA		4	4	1	1
American Lake, WA		60	56	31	23
Ann Arbor, MI		-	-	-	-
Asheville, NC		-	-	-	-
Atlanta, GA		-	-	-	-
Augusta, GA		7	19	14	9
Batavia, NY		-	-	-	-
Bath, NY		61	49	-	-
Battle Creek, NY		52	39	18	18
Bay Pines, FL		2	52	61	-
Beckley, WV		6	12	10	18
Bedford, MA		30	23	18	12
Big Spring, TX		-	-	-	-
Biloxi, MS		102	77	8	14
Bonham, TX		49	64	52	49
Brockton, MA		33	71	37	33
Brooklyn, NY		211	210	206	248
Buffalo, NY		4	-	3	-
Butler, PA		53	37	60	48
Canandaigua, NY		12	-	6	3
Castle Point, NY		241	171	148	6
Cheyenne, NY		12	6	14	11
Chillicothe, OH		-	-	-	-
Cincinnati, OH		42	58	115	87
Cleveland, OH		11	-	5	1
Coatesville, PA		9	14	36	9
Columbia, MO		55	64	84	54
Columbia, SC		6	3	-	-
Danville, IL		10	3	1	-
Dayton, OH		5	73	9	-
Dublin, GA		30	63	60	59

Facility	1980*	1981	1982	1983	1984
		Number of Veterans on the Waiting List			
East Orange, NJ		185	85	42	17
Erie, PA		17	30	43	42
Fargo, ND		49	55	47	95
Fayetteville, ND		20	2	6	36
Fort Howard, MD		5	16	6	11
Fort Lyon, CO		1	-	-	2
Fort Wayne, IN		-	-	22	36
Gainesville, FL		-	-	68	109
Grand Island, NE		-	-	1	-
Grand Junction, CO		1	3	6	7
Hampton, VA		25	39	34	-
Hines, IL		-	-	-	-
Houston, TX		-	-	-	-
Indianapolis, IN		-	-	-	-
Iron Mountain, MI		-	-	1	18
Jackson, MS		93	89	86	55
Kerrville, TX		41	75	127	156
Knoxville, IA		5	32	44	53
Lake City, FL		90	46	31	48
Leavenworth, KS		9	-	4	2
Lebanon, PA		5	1	1	-
Lexington, KY		-	-	1	-
Little Rock, AR		9	5	7	-
Livermore, PA		-	10	37	-
Loma Linda, CA		6	5	8	12
Long Beach, CA		47	28	-	8
Lyons, NJ		-	-	10	10
Manchester, NH		56	60	66	13
Marion, IN		1	4	3	2
Martinsburg, WV		8	3	19	27
Memphis, TN		-	-	9	6
Miami, FL		28	-	-	-
Miles City, MT		13	15	19	15
Montrose, NY		46	12	1	2
Mountain Home, TN		3	2	11	12
Murfreesboro, TN		19	13	15	9
North Chicago, IL		28	7	15	11
Northampton, MA		10	10	6	7
Palo Alto, CA		29	17	43	-
Perry Point, MD		-	6	1	-
Phoenix, AZ		-	-	-	-
Pittsburgh/Univ Dr, PA		67	-	25	4
Poplar Bluff, MO		-	2	-	-
Portland, OR		-	-	-	-
Reno, NV		10	11	9	37
Richmond, VA		-	-	-	-

Facility	Number of Veterans on the Waiting List				
	1980*	1981	1982	1983	1984
Roseburg, OR		19	19	28	18
Saginaw, MI		-	1	2	-
Salem, VA		16	25	7	3
Salisbury, NC		16	-	12	-
Salt Lake City, UT		-	-	-	-
San Diego, CA		12	17	5	4
Sepulveda, CA		-	-	-	-
Sioux Falls, SD		33	17	13	18
St. Cloud, MN		-	-	-	-
St. Louis, MO		62	45	71	95
Syracuse, NY		12	8	6	9
Temple, TX		-	19	3	-
Togus, ME		16	8	1	-
Tomah, WI		-	7	3	7
Topeka, KS		38	-	14	18
Tucson, AZ		20	20	36	30
Tuscaloosa, AL		61	28	28	42
Tuskegee, AL		19	4	14	28
Waco, TX		2	7	6	7
West Haven, CT		191	229	171	155
White River Jct, VT		-	3	2	5
Wichita, KS		-	-	-	21
Wilkes-Barre, PA		-	-	110	180
Wilmington, DE		4	-	-	-
Wood, WI		132	106	80	79

* Data are not available since these data were not included in any reporting system for FY 1980.

Question 26.

At the Committee's June 6, 1984, hearing on issues relating to quality assurance efforts within DM&S, the VA's testimony noted that 70 SERP visits should be conducted each year.

A.(i) How many SERP visits were conducted in FY 1984 and how many are projected to be conducted in FY 1985 and in FY 1986?

(ii) To the extent that less than 70 such visits have been or are projected to be conducted in any of those years, what is the reason for this shortfall?

(iii) To the extent that the reason is related to funding and FTEE unavailability, how many FTEE at what cost would be needed to support 70 SERP visits in FY 1986?

B. What resources, including FTEE and travel and other funds, are included in the proposed FY 1986 budget for SERP visits?

Answer 26.

A.(i) There were 41 (39 full surveys and 2 follow-up surveys) completed in FY 1984. FY 1985 funding levels will support 34 full surveys and 5 follow-up surveys. (At present time there are 5 team leaders fully trained and qualified to lead surveys, one team leader is currently in training and one vacancy exists that has not been filled.) There are 40 full surveys projected for FY 1986.

(ii) The inability to accomplish 70 surveys is related to Departmental priorities and the availability of existing resources.

(iii) To complete 70 surveys would require 7 trained team leaders with personnel service costs of $298,612 and $523,500 in .811 and .870 travel funds.

B. Funding/FTEE included in the FY 1986 budget provides resources for approximately 40 surveys, same as the FY 1985 budget.

Question 27.

What is the estimated cost to the VA in FY 1985 and FY 1986 to support the Special Medical Advisory Group (SMAG) and, in particular, what is the cost of a third SMAG meeting each year as proposed by the SMAG in that body's annual report?

Answer 27.

During FY 83 and FY 84 the cost each year to the Veterans Administration in support of the Special Medical Advisory Group (SMAG) was approximately $38,000. Biannual SMAG meetings each year accounted for approximately $21,000; subcommittee, work group and task force meetings accounted for the remaining $17,000.

It is anticipated that the cost each year to support SMAG in FY 85 and FY 86 will be approximately $50,000. This projection reflects the cost of a third meeting ($12,000) each year of the full SMAG.

Question 28.

With reference to the appropriation for the grant program to assist states with the construction of State Home facilities, which is proposed to be reduced by $12.5 million in FY 1986, what is the total number and dollar value of qualified projects that have been received by the agency and for which funding is unavailable? Please provide a listing of the projects showing the type and dollar value of each.

Answer 28.

At the time of final budget formulation in December 1984, there were 65 preapplications and applications for grants on hand totalling $151 million. Of these, the first 26 grant requests totalling $67 million are expected to be funded with the 1985 and requested 1986 appropriations. This would leave 39 grant requests total-

ling $84 million. A list of eligible preapplications and applications follows:

Eligible Preapplications and Applications for Grants for Construction of State Extended Care Facilities

(Pending approval - dollars in thousands)
12/17/84

FAI No.	State (locality)	Project	Estimated Grant Request
24-003	MD (Charlotte Hall)	(3rd Phase - 126 Dom/NH Beds)	$ 3,047
24-004	MD (Charlotte Hall)	(4th Phase - 126 Dom/NH Beds)	5,298
08-007	CO (Rifle)	New State Home - 100 NHC Beds	2,426
42-006	PA (Hollidaysburg)	Boiler Plant Modifications	597
17-007	IL (Quincy)	Renovation Andrew	351
17-008	IL (Quincy)	Energy Conservation	117
17-009	IL (Quincy)	Fire Safety	111
26-002	MI (Grand Rapids)	Replacement Mann - 226 NH Beds	11,003
06-008	CA (Yountville)	Hospital Addition - 56 Beds	6,254
06-009	CA (Yountville)	Remodel Dom - C	2,384
06-010	CA (Yountville)	Remodel Dom - A	1,808
06-014	CA (Yountville)	Rem. Sec. D Dom-Life Safety	1,853
26-003	MI (Marquette)	New State Home 155 D/N	2,652
34-009	NJ (Paramus Phase I)	New State Home - 114 Bed NH	6,108
34-010	NJ (Paramus Phase II)	New State Home - 100 Bed NH	5,054
34-011	NJ (Paramus Phase III)	New State Home - 100 Bed NH	5,131
28-001	MS (Jackson)	New State Home - 150 Bed NH	4,388
30-002	MT (Columbia Falls)	50 - Bed NH Wing	1,203
25-029	MA (Chelsea)	Elevators	78
25-030	MA (Chelsea)	Renovations	76
06-012	CA (Yountville)	Remodel Hospital Ward 1A	118
37-N003	PA (Hollidaysburg)	Renovations-NHC-Grant Increase	99
37-N004	PA (Hollidaysburg)	Renovations-DOM-Grant Increase	191
13-004	GA (Milledgeville)	150 Bed NH	5,902
27-006	MN (Hastings)	Grant Increase	474
17-010	IL (Quincy)	Life Safety-Fire Alarm	144
42-008	PA (Hollidaysburg)	Renovation-Sommer-225 NH Beds	4,091
06-013	CA (Yountville)	Rem. Sec. B to NH-Life Safety	2,179
06-011	CA (Yountville)	Cooling Plant and Piping	1,359
06-015	CA (Yountville)	Rem. Sec. E Life Safety	1,729
06-016	CA (Yountville)	Rem. Hospital Support Service	1,300
06-017	CA (Yountville)	Rem. Nursing Home	1,557
06-018	CA (Yountville)	Rem. Sec. F - Handicapped	1,299
06-019	CA (Yountville)	Rem. Workshop-Sprinkler	98
36-002	NY (Long Island)	New 350 Bed NH	14,625
06-020	CA (Yountville)	Rem. Sec. H Dom-Fire & Safety	1,105
06-021	CA (Yountville)	Rem. Sec. J Dom-Fire & Safety	1,105
06-022	CA (Yountville)	Rem. Sec. K Dom-Fire & Safety	1,105
06-023	CA (Yountville)	Rem. Sec. L Dom-Fire & Safety	1,105
06-024	CA (Yountville)	Rem. Wings 1C-D, 2C-D, 3C-D NH-Fire & Safety	1,557
05-002	AR (Little Rock)	Conversion 70 Dom beds to NH	195
42-009	PA (Hollidaysburg)	Renovate Dietary Building	1,800
44-003	RI (Bristol)	Domiciliary Renovation	1,138

FAI No.	State (locality)	Project	Estimated Grant Request
12-001	FL	New State Home 150-bed Dom	2,730
39-002	OH (Sandusky)	Grant Increase	221
29-004	MO (St. James)	Replace NHC Unit-100 beds	2,420
40-009	OK (Clinton)	New 50 bed NHC Unit	965
16-002	ID (Boise) -	Renovate Dom Wing into Dom/NHC beds	1,105
39-011	OH (Sandusky)	Add 100 NHC beds, Secrest	2,918
06-025	CA (Yountville)	Remodel Wards 2-3 E	813
06-026	CA (Yountville)	Remodel Annex I	1,170
06-027	CA (Yountville)	Remodel Annex II	1,170
06-034	CA (Yountville)	Remodel Ground & 1st Floor	650
06-028	CA (Yountville)	Remodel Dom Sec. G & LSC	1,463
54-003	WV (Pruntytown)	Remodel School for 202 NHC Phase 1	2,961
54-004	WV (Pruntytown)	Remodel School for NHC Phase II	2,602
06-031	CA (Yountville)	Renovate Kitchen & Dining Room	195
06-032	CA (Yountville)	Renovate Hospital Food Service	195
06-029	CA (Yountville)	Renovations-Storage Areas	195
06-033	CA (Yountville)	Renovations-Sprinkler System	98
06-035	CA (Yountville)	Renovations-Admin. Building	98
39-003	OH (Sandusky)	New 300 Bed Dom	9,223
39-010	OH (Sandusky)	New 200 Bed Dom	5,188
01-001	AL (Alexander City)	New 150 Bed NHC	4,615
29-005	MO (NW)	New 150 Bed NHC	5,850
			$151,059

Question 29.

With respect to two of the three major replacement/modernization construction projects -- the clinical addition/nursing home project in Philadelphia and the replacement/modernization hospital in Houston, I have several questions.

A. First, the following is an excerpt from a February 12, 1985, Philadelphia Inquirer story entitled "Budget May Cut Philadelphia VA Project". With respect to the Houston project, the article states,

"Was political influence used?

"'You bet. We had gotten word last month or so that our project was being left out [by the Edgar Subcommittee],' said Larry Neal, Gramm's press secretary. 'Let's say that we think Congressman Edgar was doing basically the same thing that we are trying to do -- get money in our districts.

"'We just do it better,' Neal gloated."

Harry what is your response to the implication that the decision to seek essentially full funding of the Houston project was politically motivated?

Answer 29A.

> There was no political consideration whatsoever in the decision to seek essentially full funding for the Houston project. We believe that it is important to receive funding for fully functional units of construction and thus not leave the potential for having a "hole in the ground". With the monies that were available to the agency in the replacement/modernization category, we considered what options would maximize the use of resources within the concept of "useable units." In the case of Houston we were only able to separate for funding in a later year the demolition and landscaping of the existing site but were required to maintain the majority of the new construction as a single unit for budget purposes. In the case of the Philadelphia project, the portion of the project which is in the budget was separable and could be proposed within the proposed budget level.

Question 29B.

It is my understanding that the Office of Management and Budget had originally supported the undertaking of only two major replacement/modernization projects in fiscal year 1986. Which two projects were initially approved by OMB for funding in fiscal year 1986 and what justification was used to add the third one?

Answer 29B.

The projects at Houston, Texas, and Mountain Home, Tennessee, were the agency's number one and two priorities in the replacement/modernization category and were thus selected as the two projects. In that additional funds were available, a portion of the Philadelphia project was proposed in the budget.

Question 29C.

Last year, the VA sought approval of $25.24 million in planning money for the construction of a 1,039-bed facility at Houston. This year, the approval is sought for an appropriation of $190 million for a facility that is 8 beds larger. What are the additional 8 beds for and why is this change not explained in the budget materials?

Answer 29C.

The adjustment of eight beds in the Houston project is a result of design considerations in the planning for the project. It was an oversight that this change was not explained in the budget materials. The differences are: Medicine -7, Intermediate +14, Surgery +5, and Psychiatry -4.

Question 30.

What is the most current profile available to the agency of the veterans who use VA health-care resources and, in general terms, what does it show in terms of the average age of veteran-patients, their income levels, and their health insurance coverage?

Answer 30.

The 1979 Survey of Veterans revealed that veteran patients who use VA medical centers are slightly older than other veterans, have need for more intensive medical care, have lower family incomes and are much less likely to be covered by medical insurance plans.

Question 31.

As you know, I have a very strong interest in the VA's efforts to come to grips with the problem of veterans suffering from PTSD. Thus, I look forward to receiving and reviewing the first comprehensive report on the agency's PTSD activities, mandated by section 110 of Public Law 98-528. This report is due to be submitted not later than March 1 of this year.

A. Will the report be submitted by that date?

B. [If no] When will it be submitted?

Answer 31.

We anticipate some delay in submission of this report beyond the March 1, 1985, due date.

The recommendations of the Special Committee are undergoing review by the Chief Medical Director and his views on these will be incorporated as a part of the report. We expect we will be able to submit this report by mid-April.

Question 32.

Last year, in our May 24 construction approval resolution, this Committee took the position that all five modernization/replacement projects for which you sought approval, as well as two which had been planned, but for which you had not sought approval, had been oversized and that the number of beds for each facility should be reduced. In arriving at these conclusions, the Committee developed a bed-sizing model that placed emphasis on the needs of service-connected disabled veterans and of financially needy veterans.

A. How was the Committee's position regarding the need for these emphases taken into account in connection with your 1986 proposal for these three projects?

B. How will the Committee's position be taken into account in sizing future replacement/modernization projects?

Answer 32.

The sizing of future replacement/modernization projects for 86 and beyond will be based on a model that was developed, at the direction of Congress, by a group from the VA and GAO. It is a well thought-out model that considers not only VA historical experience, but also community factors such as length of stay. The implementation of a bed-sizing model, such as the one developed by the Committee, should only be considered after broad public discussion and participation.

Question 33.

A. In connection with the so-called "third-party reimbursement" proposal, will the legislation you will be submitting specify that the funds collected by the VA from insurance companies are to be deposited in the U.S. Treasury as miscellaneous receipts?

B. In connection with the "means" test that you will be proposing, will the legislation you will be submitting provide that any collections by the VA for costs of care provided to certain non-service-connected disabled veterans will be deposited in the U.S. Treasury as miscellaneous receipts?

Answer 33.

A. Funds will be deposited in the U.S. Treasury as proprietary receipts not as miscellaneous receipts.

B. A final decision has not yet been made with respect to this issue.

Question 34.

On pages 2 to 4 of his testimony, Dr. Custis cites a number of examples of statements from OMB budget guidance papers and then provides his views on these statements. Please indicate whether you agree with Dr. Custis' responses and, with reference to any statement of his with which you do not agree, please indicate your views.

Answer 34.

Although time is insufficient to research completely all of these materials, we offer the following general comments:

--We confirm Dr. Custis' "fact" that the VA Aging Report estimates a projected $18 - 20 billion outlay by 2000. However, those estimates are in 1985 dollars and the OMB budget guidance papers were presented in nominal dollars and, therefore, adjusted for inflation.

--The 1979 Survey of Veterans (called "SOVII") reported that 89% of the number of respondents claimed to have health insurance. We cannot prove or disprove Dr. Custis' assertion. We possess more recent data from a recent GAO study (HRD-85-24 dated February 26, 1985) indicating that of nonservice-connected veterans who used the VA in

1982, only 18% had substantial private health insurance coverage. Another 42% had government financed health insurance. Also, a 1984 survey conducted for us by the MAXIMUS Co. showed that, of service-connected and nonservice-connected veterans using the VA, only 11% had meaningful health insurance policies. We are using the GAO study as the primary data source for estimating potential third party collections in consideration of a VA legislative proposal to be transmitted shortly to Congress.

--The term "fully covered by Medicare" is a judgemental term. It is true that nearly all citizens over the age of 65--including veterans--are Medicare-eligible. Whether Medicare "covers" a particular illness or the milieu of care necessary in a given case is another question entirely. Veterans as a class would be neither advantaged nor disadvantaged versus other citizens. We estimate that, for veterans who used the VA system in 1981, only about 9,800 who were over 65 at that time, would be required now to seek care under Medicare, based on the proposed means test. There is no question, considering the aging factor, that this number will grow. The extent to which it will grow, however, is still speculative. In his statement Dr. Custis seems certain in his belief that "coverage" will not be comprehensive. We can confirm his statement only for potential nursing home patients, whose coverage today under Medicare is quite limited and unquestionably presents a difficult problem for Medicare-eligible citizens who require long-term nursing home care. This population segment will experience more difficult financial problems in the future assuming no other alternatives are identified.

--We agree with Dr. Custis' statement concerning what is commonly called "mainstreaming." We have not heard argued previously the exclusionary clause issue as related in any way to "mainstreaming." The insurance industry has argued against changing exclusionary clauses on the basis of unconstitutionality and also as financial issue (e.g. that all health insurance premiums would rise if VA collected from third party payers). The mainstreaming issue has been debated as a matter of "privatization" (e.g. to shift VA patients to private providers at government expense, thereby conserving federal resources now appropriated for VA's infrastructure).. We believe these to be two distinct and unconnected matters; thus, we concur with Dr. Custis' assertion.

--The 1986 budget request recognizes the VA's primary mandate to care for service-connected, special category, and poor veterans. The budget is sufficient for these expressed purposes in 1986. The Administration is still considering the aging issue overall and its potential out-year impact on federal medical outlays. While true that this budget does not categorically address "aging" per se, major resource commitments are and will be expended to care for veterans, all of whom are aging. We are continuing--essentially at current service levels--the CRC, GRECC, HBHC, GEU, nursing home, intermediate and other medical and health programs. Obviously these and other programs concentrate on the range of illnesses and afflictions associated with elderly people, chronic illness and the aging process.

--We cannot establish the relative cost of VA care versus care in the private sector. We are exploring a possible cost-comparison based on the DRG concept and we anticipate completing that study later this year. We have completed one informal DRG cost-comparison between VA national costs in 1981 versus 1981 Maryland costs and found that our costs are comparable. However, a more conclusive study needs to be done.

--We confirm Dr. Custis' assertion that approximately one-third of inpatients and one-half of outpatients are service-connected veterans, or veterans with a special eligibility (POW, Atomic, Agent Orange, Pensioner, etc.). However, only 10.8% of 1983 hospital discharges were for service-connected conditions. Our best estimate is that about 2.9 million individual veterans use the VA system. Of that total 1.5 million have service-connected disabilities and 1.4 million have "special" eligibilities or are NSC.

--The Administrator has stated the VA's position on budget escalation. The VA has unquestionably made significant productivity improvements in recent years, and Congress has invested substantial appropriations for renovations and improvements in VA plant and facilities. In deflated dollars the VA's Medical Care account has not grown signficantly, but in actual outlays there has been the growth noted (in 1970, outlays were $1.5 billion and in 1985, the estimated outlays are $9.3 billion).

Question 35.

On page 4 of his statement, Dr. Custis indicates that the VA requested 2,594 FTEE to staff new activations in FY 1986 rather than the 2,068 FTEE identified in the budget documents as being provided for the new activations.

A. Is Dr. Custis correct?

B. [If yes] (i) How were the 526 FTEE to be distributed among each of the new activations and, if applicable, among existing facilities from which FTEE would be withdrawn to provide FTEE for the new activations?

(ii) How will the new activations be staffed, i.e., will an additional 526 FTEE (or some portion thereof) for the new activations be taken from existing programs or will the new activations receive less staffing than DM&S believes is needed? (Please identify any existing facilities from which FTEE will be taken to provide staff for new activations and any new activations that will receive FTEE from existing facilities and provide the number of FTEE's involved in each instance.)

Answer 35.

A. The 2,594 average employment (FTEE) referenced by Dr. Custis represents the Agency's activation average employment request to the Office of Management and Budget (OMB) in September 1985.

B(i). The revised 1986 facility activation employment request of 2,068 FTEE represents three things. First, the September 1984 estimate of 2,594 FTEE was based upon the project activations requirements in April 1984. Since the time the OMB budget was submitted, a revised estimate of 2,368 was prepared based upon a November 1984 update of projects. Second, the activation average employment (FTEE) requirements were reduced to eliminate the non-workload FTEE requirements for small projects (1 and 2 FTEE). This represents the Department's attempt to contain employment increases system-wide. Finally, the activation requirements were further reduced to reflect the impact of the one percent increase in productivity. Therefore, the 2,068 FTEE requested in 1986 reflect a revised estimate incorporating these three factors and not an underestimation of needs to be achieved through reductions at existing facilities.

B(ii). The 2,068 FTEE represent the revised 1986 activation employment needs and no additional FTEE will be needed from existing programs.

Question 36.

Please comment on Dr. Custis' statement on page 6 of his statement that "[e]mployment reduction in DM&3 Central Office may be twice the figure given of a 78 FTEE, because of lack of sufficient personnel services dollars."

Answer 36.

The fiscal year 1986 projected employment level for the MAMOE appropriation is 753 FTEE. This is 84 FTEE below the revised fiscal year 1985 level and 107 FTEE below the Congressionally adjusted fiscal year 1985 appropriation level of 860 FTEE.

In addition, if the 5% pay reduction is not enacted and offsetting funds are not provided, a further reduction of 27 FTEE would be required. Further reduction of up to 6 FTEE could also be required if projected savings from the GS 11-15 reduction do not materialize.

All calculations have been made based on the MAMOE average salary of $43,064 which equates to the average salary of a GS 13. An employment reduction based on employee turnover and not on a reduction-in-force would probably be skewed toward the lower grades creating an FTEE loss larger than what an average salary projection would indicate. This is probably the basis for Dr. Custis' statement.

Question 37.

Also on page 6, Dr. Custis states:

> My chief concern, however, has to do with what the projected outyear numbers portend for the future integrity of the VA health care system. Policy is clearly being made through the budget process and OMB's announced intent is to eliminate another 8,000 health care employees by 1990, provide no resource enhancement in anticipation of the impact of the aging vereran and only permit new construction based on "service-connected demographic justification."

Do his statements accurately portray the Administration's position? Please indicate any disagreement you have with his portrayal thereof.

Answer 37.

The future year projections for the Medical Care account are considered "plug numbers". Resource needs in future years will be based on the needs of veterans. Current policy negotiations including the dvelopment of a "means test", third-party reimbursement and the recommendations of a White House task force looking into the entire health care issue will be considered as future year budgets are developed.

Question 38.

Last year, in connection with the preparation of the Committee's May 24, 1984, construction authorization resolution, VA hospital census data was obtained showing (agencywide and for the seven proposed projects approved in our 1984 resolution) percentages of hospitalized veterans (1) who are service-connected disabled veteans receiving care for their service-connected disabilities, (2) who are service-connected disabled veterans receiving care for non-service-connected conditions, or (3) who are in receipt of VA need-based pension. Please provide updated data for these categories agencywide and for each of the three major replacement/modernization projects proposed in the fiscal year 1986 budget (Houston, Mountain Home, and Philadelphia) and for Baltimore.

Answer 38.

The FY'84 PTF and outpatient sampling file reveals the following, which are relevant for the present facility size only

Inpatient:

	Average	Houston	Mt. Home	Philadelphia	Baltimore
Receiving Care for SC	10.3%	7.9%	5.7%	13.1%	6.7%
SC Receiving Care for NSC	19.5%	14.3%	21.9%	16.9%	17.9%
In Receipt of Pension	17.9%	14.3%	27.0%	15.6%	27.6%
SC Veterans Receiving Outpatient Care	51%	34.4%	52.9%	56.3%	49.7%

Question 39.

The American Legion, on page 3 of its testimony, states:

> An increase in the loan origination fee from 1 percent to 5 percent on all guaranteed and vendee loans is proposed. The American Legion is opposed to this increase. In practical effect, it would eliminate the advantage of enabling a veteran to purchase a home with no down payment.
>
> Another loan guaranty proposal would allow for borrower/lender negotiated rates on guaranteed and vendee loans; and terminate the Administrator's authority to set interest rates. We oppose this action, as it would drive interest rates up, and put veterans out of the housing market.

Please state whether or not you agree with the Legion's assessments of the effects of these proposals and, if not, why not.

Answer 39.

If a 5 percent fee was to be financed, it would increase the monthly payment on an average loan at 12.5 percent interest rate by approximately $29. Veterans would, however, still be able to purchase a home with no down payment, a payment that is not available to FHA or conventional home buyers.

Although VA makes every effort to reflect the loan market in setting interest rates on guaranteed home loans, it is not always possible for such rates to keep exact pace with money market demands. When the costs of money is not adequately reflected by the VA interest rate, lenders are required to charge points to bring their yield into line with secondary market demands. One "point" equals 1 percent of the loan amount. The points must be paid in cash at loan closing. VA has interpreted the law as not permitting veterans to pay points, except under certain limited circumstances spelled out in 38 U.S.C. S 1803(c)(3); e.g., refinancing and home improvement loans. This is because if the veteran paid this amount he or she would, in effect, be paying an interest rate above the permitted maximum. Thus, the seller is required to absorb these costs.

Sellers who are reluctant to pay points often either refuse to sell with VA financing, or increase the selling price of their home to reflect the acticipated points. In neither instance is the veteran being benefited.

Under the proposal to allow for a "negotiated rate," the veteran buyer, the seller, and the lender can negotiate as to what the interest rate will be and who will pay all or some of the points. Thus the transaction can be tailored to fit the needs and circumstances of the parties involved.

This change would be consistent with the Administration's goal of reducing Federal regulation and permitting the free market to control. We know of no evidence to indicate that interest rates in general will be driven up by this change in VA's home loan program.

Question 40.

On page 4 of its testimony, the American Legion states, in connection with the third-party reimbursement proposals:

> We have heard statements made by VA officials during Congressional hearings to the effect that the administrative costs necessary to implement the mechanism for collection of insurance payments would probably exceed the costs that are recovered.

Please give your FY 1986 estimates of gross receipts and of the costs of implementation of this proposal and the assumptions for each estimate.

Answer 40.

Although figures have not been finalized, it is expected that third party receipts will well exceed the costs of implementation.

Question 41.

With respect to the proposed consolidation of DVB, the Paralyzed Veterans of America in its testimony points out:

> Bearing on the logistics of consolidating all active claims folders in three centralized locations, consideration will have to be given to the sheer immensity of the files storage problem. Based upon representative inventory figures obtained from what we consider an average sized Adjudication Division, we have made the following assumptions and computations. Of the approximate 105,000 C-Files in that office, 90,000 are considered active. They are housed in filing cabinets which are fifteen inches wide and approximately twenty-five inches deep. These 5-drawer cabinets have an average of 40 files per drawer or 200 per cabinet. We have conservatively extrapolated a total of 5,220,000 active files in the United States based on multiplication of 90,000 by 58 RO's.
>
> Dividing this total number of active files by 200 gives us a requirement of 26,100 cabinets which, taking a total of 1.25 linear feet (width) each, comes to 32,625 linear feet or a national total of six miles of cabinets or two miles of cabinets per consolidated office. In terms of area, these cabinets require 5.2 square feet each (including a 25 inch aisle) or a total of 135,720 square feet or approximately 45,000 square feet of space for the cabinets alone in each consolidated office. Add to this the square footage of the requirements for cross aisles and working space for the employees, their necessary equipment, and adjunct facilities.
>
> The sheer immensity and volume of folders per regional office, conservatively at least 1.75 million files per office, further presents the question of the time factors which must be considered for obtaining any given file. Of much more serious consequence is the ever-present danger of a major loss of C-Files, with all of their irreplaceable military and personal records, correspondence, etc., in the case of a catastrophic fire, comparable to the disaster at St. Louis in the early seventies when many millions of irreplaceable veterans' records were destroyed. Many a veteran undoubtedly suffered a denial of his claim, solely due to the fire.

At the hearing, Jack Powell, PVA Executive Director, revised these figures based on the assumption of 183,000 files for an average-sized regional office Adjudication Division. Thus, his revised computations indicated 10,614,000 active files; a requirement of 53,076 cabinets, which is 12.5 miles of cabinets, or about 4 miles of cabinets per consolidated office; a total of 276,000 square feet of cabinets, for 92,000 square feet of cabinets per consolidated office; and a total of 3.5 million files per consolidated office.

In light of his revised analysis, please comment on the problems of file storage and retrival that might result if the existing regional offices are consolidated into 3.

Answer 41.

We realize the magnitude of files storage and retrieval operations would be a problem at a consolidated location. Accordingly, the most efficient and safest method to manage files operations will be utilized should a decision be made to consolidate.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON.
ARLEN SPECTER, A U.S. SENATOR FROM THE STATE OF PENNSYLVANIA

Question 1.

The largest budget savings in the VA is expected to come from legislation to establish a means test for medical care for non-service-conneceted disabled vets; OMB estimates a $363 million savings in fiscal year 1986 and $2.1 billion over 3 years (Congressional Quarterly).

Does the VA have sufficient data to prove that those using the VA health system are affluent?

Answer 1.

The Veterans Administration expects to formally receive GAO income data for VA users that will allow an analysis. Prior studies have generally indicated that the veterans utilizing VA facilities are not affluent.

More importantly, it should be pointed out the means test is a matter of fairness - to assure that demands for medical care are addressed on the basis of need, rather than age, and that all non-service connected veterans are treated equally.

Question 2.

On average, is treatment less expensive when provided to vets at a VA facility than care provided by Medicare and Medicaid?

Answer 2.

The Department of Medicine and Surgery is in the process of conducting a study on the comparison of costs of care for Medicare patients and VA patients. Results of this study are expected to be available in August or September.

We do not anticipate excluding patients who are eligible for Medicaid as their income levels will not result in exclusion by application of the means test.

Question 3.

If it is, why shift the responsibility of caring for veterans to more expensive care with less control over the quality of care?

Answer 3.

The demand for VA care is expected to exceed our capacity. The means test will focus the VA's delivery of care to the truly needy non-service connected veteran, in addition to the service connected and other special categories of veterans.

Question 4.

How many vets does the VA believe will have sufficient incomes not to qualify for VA service, and will not be eligible for Medicare and Medicaid? Will some vets be forced to exhaust their resources before they become eligible for assistance?

Answer 4.

Those veterans over age 65 who would be excluded from VA care as a result of the means test would retain their eligibility for Medicare, while the group under age 65 who would not be automatically eligible, would not be eligible for Medicaid. No veteran would be required to exhaust their resources. The proposed means test would function in the following manner:

Non-service connected veterans whose annual family incomes including assets (as defined in the Improved Pension Program) are below double the maximum annual VA pension rate based on family size, would be deemed unable to defray necessary medical expenses. Out of pocket medical expenses for other family members would reduce the gross family income for determining eligibility.

For NSC veterans whose gross annual family incomes including assets are in excess of double the maximum annual VA pension rate, procedures would be established by regulation identifying the conditions under which veterans may be considered unable to defray further expenses and VA care could be provided for a particular medical service.

--Except for veterans requiring emergency care and care in certain extraordinary circumstances, such veterans would not be eligible for VA health care until the veteran's out-of-pocket medical expenses exceed certain levels. These medical expense levels, are termed the "expected medical expense contribution."

--The expected medical expense contribution would form the basis of a means test procedure to evaluate the veterans inability to defray further medical costs.

The following schedular display would be used.

Income Interval as a Percent of Double the Pension Maximum Annual Rate	Expected Medical Expense Contribution as a Percent of Income in Excess of Double the Pension Maximum Annual Rate
100% - 116.7%	25%
116.8% - 133.3%	35%
133.4% - 200.0%	50%
200.1% - 566.7%	75%
566.8% - and over	90%

If the veteran presented reasonable evidence that out-of-pocket payments for his/her care to private providers and third parties during the preceding twelve months equaled or surpassed the expected medical expense contribution, the veteran would be admitted. The precise evidence acceptable to VA and pertinent to such claims would be defined in regulations.

Veterans requiring emergency care and care in certain extraordinary circumstances could be admitted for VA care, but would be billed for the cost of such care up to their expected medical expense contribution. These terms would be further defined in regulation. In addition, the veteran would be billed up to his expected medical expense contribution for any examination provided to determine if emergency care is required.

For treatment of these NSC veterans, if the veteran is covered by a private insurance plan, the private plan would be required to reimburse the VA for medical expenses incurred by the patient that are covered by the plan. The VA would bill the veteran the difference between the insurance company payments and actual VA costs, but not in excess of the veteran's expected medical expense contribution.

Waiver Authority

In exceptional, unusual, and rare circumstances, the Administrator could waive the veteran's expected medical expense contribution.

The Administrator would have authority to grant waivers for a portion or all of an individual veteran's medical expense contribution limited to the period of the episode of care for which the veteran claimed relief. Such waivers would only be considered upon application of the individual veteran, and a demonstration by the veteran that the contribution would effect an unusual and exceptional hardship on the veteran. Such waivers will not be granted categorically, either for categories of illness, expenses, incomes, procedures, or for veterans. The Administrator would issue regulations setting forth the procedures for granting such waivers. The Administrator's decision to grant or not to grant a waiver would not be subject to judicial review.

Grandfather Clause

This new procedure would be implemented prospectively; VA would not apply the means test for patients in a treatment status at the time of implementation of such new procedures. This grandfathering provision would apply only through the duration of the episode of care.

Question 5. In dollars and cents, what average additional expenses will higher eligibility requirement mean to WW II veterans reaching age 65.

Answer 5. There is no data available for estimating the average additional expenses for WW II veterans as a result of the means test. In reviewing our proposed procedures for implementation of the means test, outlined, in our answer to question 5, it can be seen that each individual nonservice connected veteran excluded may become eligible after meeting a required medical expense contribution that varies depending on income level.

Question 6.

The Philadelphia VA Medical Center which received $17.7 million for FY85 for site prep is in the FY86 budget for $12 million to build the 240-bed nursing home and a pedestrian bridge, and in the FY87 budget plan for $98.4 million to complete the renovation and the construction of the hospital project. Mr. Tom Williams, Director of the Medical Center, informs me that the hospital project is on schedule and that they will be ready to receive the total remaining $110.4 million in FY86 if it is made available.

Why the one fiscal year delay in funding when the project will be ready to obligate all of the funds in FY86?

Answer 6. After Executive review, the monies allocated in the Replacement/Modernization category were insufficient to fully fund three major projects. It would only be possible to obligate the NHCU portion of the funds for Philadelphia in FY 1986. The two projects with the highest priority were selected for funding. Phase II, the 240-bed nursing home, is a separate, self-sustaining portion of the project that can be funded with the remaining monies. When funding is available for the other phases of the project in FY 1987, there will be minimal disruption to the overall construction schedule.

Question 7. Are the Houston VA Hospital and Mountain Home, Tennessee, projects on schedule and will they be ready to obligate their full funding in FY 86?

Question 8. If they will not be ready, how much of the project will be ready to obligate?

Answers 7 & 8. Current schedule for the Houston Replacement/Modernization project anticipates an award for Phase I (earthwork, foundations, and framing) for the hospital building during the third quarter of FY 1986. Phase (remainder of the building) is scheduled for award in the second quarter of FY 1987. Phase IV (renovation of Buildings 7 and 211) is also scheduled for the third quarter of FY 1987 and Phase III (demolition, landscaping and renovation of Building 20) is scheduled in the second quarter of FY 1987. Current estimated completion of the entire project is late 1990.

Phase I (site development and construction of a temporary building) of the Mountain Home Bed Towers/Renovation project is scheduled for award in the spring of 198[illegible]. Phase II award (construction of the new bed towers) is currently scheduled in the third quarter of FY 1986. Phase III (renovation of existing building) is anticipated to be awarded during the fourth quarter of FY 1988. The new bed towers will be complete in 1988 and renovations will be complete in 1990.

Question 9. Do you agree that projects that are ready to proceed should take priority over those that are not?

Answer 9. All projects that are ready to proceed are considered in the budgetary process, and all projects are prioritized. Budgetary constraints, however, may reduce the number of projects considered.

Question 10. Which projects did OMB recommend that VA include in the FY 1986 budget and for what amounts?

Answer 10. All of the projects in the President's budget were recommended by OMB and included by the VA.

Question 11.

The FY 1986 VA budget requests a $5.3 million reduction in the Medical and Prosthetic Research program and would eliminate 157 FTEE from the 1985 level. This request would provide continued support for ongoing programs directed at research technology and health care problems. Specifically, what research programs will be cut and how will this affect the ability of the VA to serve veterans who suffer from related health problems?

Answer 11.

The proposed reduction in dollars and FTEE in FY 1986 budget will result in the following program reductions:

	Estimated No. Programs Reduced from FY 1985-1986
Investigator initiated research	40
Career Development	15
Cooperative Studies	1
High Priority Programs	6

The reduction of this number of research programs will not impact on the ability of the VA to serve veteran patients.

Question 12.

The budget proposal increases the fee charged borrowers of VA-insured home loans from 1 to 5 percent of loan principal to save $405 million in FY86.

With such high foreclosure rates and difficult times. for vets, how will this change affect the number of veterans who will qualify for future loans?

Answer 12. On VA-guaranteed loans, the funding fee may be included in the loan amount; that is, veterans are and will continue to be able to purchase a home with no downpayment. If the increase in the funding fee was to be financed, it would raise the monthly payment on an average loan of $68,000 at 12½% interest rate by approximately $29. This increase in payment should not have a significant impact on veterans being able to qualify for future loans.

Question 13. With such a high charge for the borrowers, what does the advantage in financial terms mean to a vet?

Answer 13. The program will still be attractive because of its basic features, i.e., no money down, fully assumable loans, and no prepayment penalty.

Question 14.

As part of the President's budget package, the VA intends to reorganize and consolidate the field office functions of the present 59 regional offices of the Department of Veterans' Benefits (DVB) in three processing centers.

How will this consolidation and staff reductions impact the amount of time needed and quality of work for completing cases and providing benefits?

Answer 14. On Februrary 11, 1985 a meeting was held between the VA Administrator and the Deputy OMB Director. At that time it was agreed that VA would develop a plan for modernizing its entire operations and will be considering various efficiency alternatives, one of which will be DVB consolidation. This effort has just begun and, when it is completed, a decision will be made as to the best course of action to be taken concerning DVB. When these decisions are finalized, the Department will be able to respond in greater detail.

Question 15. How many jobs would Pennsylvania lose if a regional office was not placed in the Commonwealth?

Answer 15. We are not in a position to know the impact of consolidation, should it occur. When the Department's plan for modernizing operations is completed, we will be able to respond in greater detail.

Question 16.

As the sponsor of Agent Orange legislation in the 98th Congress, S.374, and as a cosponsor of the legislation which was finally enacted, the Veterans' Dioxin and Radiation Exposure Compensation Standards Act, I am deeply interested in monitoring and ensuring prompt and effective implementation of this Act.

I am pleased to see that the VA has this week announced the designation of the members of the Advisory Committee. When will they first meet to begin their scientific review of diseases having a possible relation to Agent Orange or radiation?

Answer 16. The first meeting of the Veterans' Advisory Committee on Environmental Hazards is tentatively scheduled for April 22 and 23, 1985. The meeting is scheduled to begin at 9:30 AM on both days in the Omar N. Bradley Conference Room at VA Central Office.

Question 17.

As the sponsor of Agent Orange legislation in the 98th Congress, S.374, and as a cosponsor of the legislation which was finally enacted, the Veterans' Dioxin and Radiation Exposure Compensation Standards Act, I am deeply interested in monitoring and ensuring prompt and effective implementation of this Act.

Under the Act, the proposed regulations must be issued by April 24 of this year. Will this deadline unequivocally be met?

Answer 17. The proposed rules for implementing Public Law 98-542 must be reviewed by the Office of Management and Budget prior to publication in the Federal Register. We expect to refer the proposed regulations to OMB by mid-March 1985, and they will be published as soon as OMB approval is received. While we anticipate publication in time to meet the legislative deadline, we cannot make an unequivocal statement to that effect.

Question 18.

As the sponsor of Agent Orange legislation in the 98th Congress, S.374, and as a cosponsor of the legislation which was finally enacted, the Veterans' Dioxin and Radiation Exposure Compensation Standards Act, I am deeply interested in monitoring and ensuring prompt and effective implementation of this Act.

The Act provides for immediate interim payments for two diseases associated with Agent Orange -- chloracne and PCT. Have any payments been made to any individual under this authority? (If so) Please specify. (If not) Why not?

Answer 18. At this time we do not know of any payments being made under the interim benefit provisions of Public Law 98-542. We are, however, directing a review of specific cases in which the diagnosis of chloracne or porphyria cutanea tarda has been established but service-connection has been denied. This review is to determine whether the facts and circumstances in those cases establish eligibility for payment of interim benefits.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. DENNIS DECONCINI, A U.S. SENATOR FROM THE STATE OF ARIZONA

Question 1. If a means test is established for nonservice-connected VA health care, including veterans over age 65, what are the anticipated savings projected to be in Arizona? What is the basis for the projected savings? Did you consult with the Directors of the Arizona VA Medical Centers prior to making your projections?

Answer 1. Data available at this time does not permit reliable estimates of potential savings/cost avoidance on a state by state basis. Our primary data source for estimating the population that would be affected by the means test is a GAO draft report which compared IRS income data and VA PTF data for FY'81. This data provided to us by GAO does not reflect state breakouts.

Question 2. With the implementation of the DRG concept in the Department of Medicine and Surgery, can you provide me with information on the schedule for shifting of resource allocations under this concept? What are the implications for either an increase or decrease in funding and FTEE for the three Arizona VA Medical Centers under the DRG concept for the next three fiscal years?

Answer 2. For the current fiscal year, 1985, the shift in resources under the DRG - based allocation model was limited to the direct acute care portion of a hospital's budget. On average the direct acute care budget portion was 36.5 percent of total hospital budgets. Of this amount the lesser of 1 percent of the 36.5 percent or 20 percent of the total recommended change was shifted. In 1986, it is expected that the direct acute care, ambulatory care, and long term care portion (on average two thirds of a hospital's budget) will be subject to resource allocation models. It is currently proposed that the lesser of 3 percent of the amount subject to the models or 60 percent of total recommended changes will be shifted.

While the degree of shift for future years is yet to be determined, it is planned, that by 1990 or 1991, 80 percent to 90 percent of a hospital's activities will be subject to an allocation model and the full changes indicated will be made.

FTEE ceilings, while affected by funding, are not targeted in the resource models; only actual funds are increased or decreased.

For 1985, the three Arizona VA hospitals were affected by the DRG model in the following ways:

Phoenix: gained $214,384

Prescott: gained $ 41,027

Tucson: gained $188,286

For 1986, the final figures using acute, ambulatory, and long-term care models are not yet available. For 1987, the figures will not be known until 1985 workload and expenditure statistics are closed out.

Question 3. It is my understanding that the Department of Medicine and Surgery is considering creating a new medical district which would include Arizona. What states will be included in the new district? What was the rationale for making this decision? How will Arizona be impacted from the standpoint of FTEE and funding allocations, by facility, for the three years subsequent to the establishment of this new medical district?

Answer 3. The proposed reorganization of DM&S, which would create a seventh region, would have no impact upon the alignment of medical centers within medical district #25. Minor changes occurring in other medical districts would reduce the total number of districts to 27 and the current district #25, which incorporates the Arizona facilities, would become district #24 and be part of the newly created Region 7.

No financial changes will occur as a result of the geographic changes, which are being considered. Those realignments which are approved are being made as a result of current patient referral patterns.

Question 4. What problems, if any, are you experiencing in providing readjustment counseling services to Vietnam veterans residing in areas where there are no Vet Centers? What is the total amount of contract money available for these services in Arizona? Please provide me with the amount made available to each of the three Arizona VA Medical Centers as well as an estimate of demand for these monies at each Arizona facility.

Answer 4. There are significant numbers of Vietnam era veterans who reside in areas that are distant from a vet center or VA medical center. In those instances where a Vietnam era veteran lives a considerable distance from a VA health care facility, to include a vet center, the Agency will refer that veteran to the closest fee/contract provider. Approximately 360 fee/contract providers are scattered throughout the United States and these facilities offer readjustment counseling services to eligible Vietnam era veterans through a contract with the Veterans Administration.

See attachment A, in response to your question relative to the total amount of contract money available for these services in Arizona.

We expect that the demand will continue at a rate that will use up all funds earmarked for these three VA medical centers.

Question 5. In the FY 85 HUD-Independent Agencies Act, P.L. 98-371, Congress mandated the expansion of the Vet Center Program by 200 FTEE. It also added $8.5 million to accomplish this task. What is the current status of this expansion effort? Please indicate when you expect the 52 additional Vet Center sites to be in operation and indicate the total budget to fund these centers in FY 86.

In addition, indicate the amount of money the VA plans for the Vet Center program (FY 87-90).

Answer 5. The number of new FTEE for the Vet Center Program is 220. We project that all of the 52 new vet centers and satellites will be fully operational by July 1985. This will provide us with a total of 189 counseling sites by the end of FY 1985. An attached chart (Attachment B) provides the new site locations. Of the authorized 220 FTEE, 60 have been hired.

The FY 1985 estimate for the Readjustment Counseling Program is $40,621,000, inclusive of travel and $8 million dollars in funding for fee/contracts. The FY 1986 budget will be the FY 1985 base ($40,621,000) plus increases for inflation and any pay requirement changes. We cannot project the budget for FY 1986, until annual budget plans have been submitted to VA Central Office and approved in final form. The dollar limit for FY 1985 and 1986 for fee counseling contracts is $8 million dollars.

Also attached (Attachment C) is a special analysis for the Readjustment Counseling Program. Please note that the budget year and outyears (1986-1990) do not include uncontrollable increases for inflation. The budget year (1986) amounts for readjustment counseling will be based upon field feedback.

Attachment A

FY 1985 VA Fee/Contract funds for Readjustment Counseling Service in the State of Arizona

Locations	Dollars earmarked	Dollars obligated
Phoenix	$143,000	$65,445
Tucson	$ 8,700	$ 3,936
Prescott	$ 10,000	$ 5,000

Attachment B

REGION I EXPANSION SITES

Batavia, NY VAMC/Rochester, NY Vet Center

Boston, MA VAMC/Lowell, MA Satellite

Brockton, MA VAMC/Worchester, MA Satellite

Newington, CT VAMC/Norwich, CT Satellite

Providence, RI VAMC/New Bedford, MA Satellite

San Juan, PR VAMC/Arecibo, PR Satellite

San Juan, PR VAMC/Ponce, PR Satellite

Syracuse, NY VAMC/Syracuse, NY Vet Center

REGION II EXPANSION SITES

Durham, NC VAMC/Greenville, NC Vet Center

Erie, PA VAMC/Erie, PA Vet Center

Huntington, WV VAMC/Charleston, WV Satellite

Martinsburg, WV VAMC/Martinsburg, WV Satellite

Mountain Home, TN VAMC/Johnson City, TN Vet Center

Salem, VA VAMC/Roanoke, VA Vet Center

Salisbury, NC VAMC/Greensboro, NC Vet Center

Washington, DC VAMC/Fairfax County, VA Vet Center

Wilkes-Barre, PA VAMC/Scranton, PA Vet Center

Wilmington, DE VAMC/Pleasantville, NJ Vet Center

REGION III EXPANSION SITES

Bay Pines, FL VAMC/Sarasota, FL Vet Center

Biloxi, MS VAMC/Pensacola, FL Vet Center

Biloxi, MS VAMC/Biloxi, MS Satellite

Charleston, SC VAMC/Savannah, GA Vet Center

Columbia, SC VAMC/Columbia, SC Satellite

Lake City, FL VAMC/Tallahassee, FL Vet Center

Miami, FL VAMC/Palm Beach County, FL Vet Center

Nashville, TN VAMC/Chatanooga, TN Vet Center

Shreveport, LA VAMC/Shreveport, LA Vet Center

Attachment B-- Continued

REGION IV EXPANSIO SITES

Chicago(LS), IL VAMC/Gary, IN Vet Center

North Chicago, IL VAMC/North Chicago, IL Vet Center

St. Louis, MO VAMC/Springfield, IL Vet Center

St. Louis, MO VAMC/St. Louis, MO Satellite

REGION V EXPANSION SITES

Denver, CO VAMC/Boulder, CO Vet Center

Fort Harrison, MT VAMC/Missoula, MT Vet Center

Houston, TX VAMC/Houston, TX Vet Center

Iowa City, IA VAMC/Moline-Rock Island, IL Vet Center

Salt Lake City, UT VAMC/Pocatello, ID Vet Center

Salt Lake City, UT VAMC/Provo, UT Satellite

San Antonio, TX VAMC/Corpus Christi, TX Vet Center

Temple, TX VAMC/Austin, TX Vet Center

REGION VI EXPANSION SITES

Albuquerque, NM VAMC/Santa Fe, NM Satellite

Amarillo, TX VAMC/Amarillo, TX Vet Center

Amarillo, TX VAMC/Lubbock, TX Vet Center

Big Spring, TX VAMC/Midland, TX Vet Center

Loma Linda, CA VAMC/San Bernadino County, CA Satellite

Martinez, CA VAMC/Sacramento, CA Vet Center

Palo Alto, CA VAMC/Santa Cruz, CA Vet Center

Portland, OR VAMC/Salem-Corvallis, OR Vet Center

Prescott, AZ VAMC/Prescott, AZ Vet Center

San Diego, CA VAMC/San Diego County, CA Satellite

West Los Angeles, CA VAMC/Santa Barbara, CA Vet Center

White City, OR VAD/Eureka, CA Vet Center

White City, OR VAD/Medford, OR Satellite

Attachment C

REV 3/4/85

VETERANS ADMINISTRATION

SPECIAL ANALYSIS---READJUSTMENT COUNSELING

MEDICAL CARE

(dollars in thousands)

Resource Requirements	1983	1984	1985	3/ 1986	1987	4/ 1988	1989	1990
Obligations								
VA Facilities	20,828	21,259	31,661	31,661	31,661	31,661	23,746	15,831
Contract Care	11,200	9,403	8,000	8,000	8,000	8,000	6,000	4,000
Study	0	1,610	0	0	0	0	0	0
(Travel...007)	628	619	960	960	960	960	720	480
Total	32,656	32,891	1/ 40,621	2/ 40,621	40,621	40,621	30,466	20,311
Average Employment(FTEE)	567	572	1/ 794	794	794	794	596	397
Program Detail:								
Number of Centers	135	137	1/ 189	189	189	189	140	94
Number of Visits-Staff	643,985	651,091	750,000	900,000	850,000	750,000	562,500	325,000
- Fee	104,143	140,290	140,290	100,000	100,000	100,000	75,000	50,000
Total Visits	748,128	791,381	890,290	1,000,000	950,000	850,000	637,500	375,000

1/ As a result of Congressional appropriation action, $8.5 million and 220 FTEE were added for the establishment of 52 vet centers.

2/ The budget year and outyears (1986-1990) do not include uncontrollable increases for inflation. The budget year (1986) amounts for readjustment counseling will be based upon field feedback.

3/ The 1986 and outyear estimates have not been adjusted for the government-wide 5 percent pay reduction and 1 percent productivity increase. (A final determination of the impact on this program has not been made.)

4/ Legislative authority for this program (Public Law 98-160) extends through 1988.

Question 6. How were the readjustment counseling program resource levels impacted by the FY 85 congressional add-on, absorption of pay raises and employment reductions. In addition, describe how the FY 86 5 percent pay reduction and employment reduction associated with the 1 percent increase in productivity will impact the program budget.

Answer 6. (See Attachment D).

Question 7. The FY 1985 HUD - Independent Agencies Appropriation Act, P.L. 98-371, contained approximately $8.8 billion for the VA medical care account. When Congress passed this measure, the funding was specifically intended to support 193,941 FTEE. As I understand it, this figure of 193,941 FTEE has been allocated but sufficient funds are being requested to meet an employment level of only 191,849. Can you explain this discrepancy? What impact will this reduction in FTEE have on the quality of care in the VA medical system? How many FTEE will each of the Arizona VA medical centers lose if the employment level is reduced to 191,849?

Answer 7. The 1985 current average employment (FTEE) estimate of 191,849 is 2,092 below the level appropriated by Congress (193,941 FTEE). The 2,092 FTEE reduction from the appropriated level is the result of three things. First, as a result of the Deficit Reduction Act of 1984 employment will be reduced by 133 FTEE. Second, a 9 FTEE reduction in jurisdictional FTEE reflects a transfer from jurisdictional FTEE to common service FTEE and more accurately reflects field support provided by the Department of Veterans Benefits. The third reduction of 1,950 FTEE reflects the impact of absorbing 50% supplemental pay requirements in accordance with the Government-wide policy requiring Agencies to absorb a minimum of 50% of these pay requirements.

The 1985 current FTEE estimate of 191,849 will enable the Agency to provide the budgeted level of services, both patients treated and outpatient visits. Every effort will be made to minimize the impact of the employment reduction while treating the greatest number of patients in 1985. There will be no effect on the quality of care.

The 1985 FTEE reduction (1,950) will be incorporated into the overall 1986 Target Allowance process, which has yet to be accomplished. Until that process has been completed facility specific distributions will not be known.

Attachment D

REV 3/4/85

VETERANS ADMINISTRATION
SPECIAL ANALYSIS—READJUSTMENT COUNSELING
MEDICAL CARE
(dollars in thousands)

Resource Requirements	1983	1984	1985	1986 3/	1987	1988 4/	1989	1990
Obligations								
VA Facilities	20,828	21,259	31,661	31,661	31,661	31,661	23,746	15,831
Contract Care	11,200	9,403	8,000	8,000	8,000	8,000	6,000	4,000
Study	0	1,610	0	0	0	0	0	0
(Travel...007)	628	619	960	960	960	960	720	480
Total	32,656	32,891	1/ 40,621	2/ 40,621	40,621	40,621	30,466	20,311
Average Employment(FTEE)	567	572	1/ 794	794	794	794	596	397
Program Detail:								
Number of Centers	135	137	1/ 189	189	189	189	140	94
Number of Visits-Staff	643,985	651,091	750,000	900,000	850,000	750,000	562,500	325,000
- Fee	104,143	140,290	140,290	100,000	100,000	100,000	75,000	50,000
Total Visits	748,128	791,381	890,290	1,000,000	950,000	850,000	637,500	375,000

1/ As a result of Congressional appropriation action, $8.5 million and 220 FTEE were added for the establishment of 52 vet centers.

2/ The budget year and outyears (1986-1990) do not include uncontrollable increases for inflation. The budget year (1986) amounts for readjustment counseling will be based upon field feedback.

3/ The 1986 and outyear estimates have not been adjusted for the government-wide 5 percent pay reduction and 1 percent productivity increase. (A final determination of the impact on this program has not been made.)

4/ Legislative authority for this program (Public Law 98-160) extends through 1988.

RESPONSE OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON.

GEORGE J. MITCHELL, A U.S. SENATOR FROM THE STATE OF MAINE

Question 1.

Unit Dose

In its Budget Views and Estimates for Fiscal Year 1985 report to the Budget Committee last year, this Committee recommended increased funding and FTEE levels for the purpose of converting system hospital beds to unit dose medication. The report said (p.22), "Selection of the actual facilities for conversion should be left to the VA's resource allocation criteria."

A. What were the FY85 resources, both funding and staffing, that were expended by the VA in the conversion effort?

B. What criteria does the VA use in selecting facilities for unit dose conversion?

In its written response 26A to Senator Cranston on the FY85 Budget last year, the VA said, "...It is anticipated that resources will be requested during the 1986 budget process for the conversion of the (system's) remaining beds to unit dose."

C. What is the status of the DM&S effort to convert beds to the unit dose system and its plans for future conversion? In your response, please provide specific detail on hospital beds in Medical District I and Region I.

D. What resources are being requested by the VA in FY86 to continue the conversion to unit dose?

The Togus, Maine, Medical Center would like to implement a unit dose conversion. It is my understanding that the Center conducted a six-month feasibility study of conversion in 1983; has spent approximately $220,000 on necessary pharmacy construction and equipment purchase; and has already conducted training of pharmacy personnel.

E. In September 1984, Togus submitted a proposal to implement a unit dose conversion to Region I. What is the status of that submission?

Answer 1.

A. The VA received 1.7 million dollars for recurring monies representing 85 FTEE to convert approximately 2,380 beds to unit dose.

B. The VA uses several criterion in the VAMC site selection process for unit dose conversions. The following list represents the primary criteria used in the selection process:

- geographical hiring availability of pharmacists and salary level has become one of the most important factors for consideration during the past four years;

- scheduled or recent completion of construction projects that included provisions for pharmacy space according to space criteria requirements;
- established priorities of the six Regions and VACO Pharmacy Service;
- partial conversions previously initiated from local resource funding commitments.

C. The VA has been funded for approximately 70% (61,800+ beds) representing 123 VAMC's by the end of FY85.

- Future conversions and completion of the program VA-wide is dependent upon Agency priorities and the yearly approved funding support of the conversion process.

- Northeastern Region 1 has been funded for approximately 8,650+ beds and 16 VAMCs of the total authorized beds and facilities within the Region.

- Medical District 1 has been funded for approximately 1418+ beds and four VAMCs of the total authorized beds and facilities within the District.

D. There is no new funding being requested in FY86.

E.

- There were no additional special funds available in FY85 to support unit dose conversions after receipt of the Togus request for funding of needed resources.

- The Togus VAMC was advised that a higher priority ranking would be assigned because of their recent completion of their pharmacy space renovation. Their request will remain in an action file for consideration dependent upon future funding support availability.

Question 2.

Eligibility For VA Health Care

In its FY86 Budget, the Veterans Administration has proposed revising eligibility for free VA medical care by requiring certain nonservice-connected disabled veterans, regardless of age, with incomes above a determined standard to use a portion of their resources to pay for all or part of the cost of VA-provided medical care.

A. OMB document, "Background on Major Spending Reforms And Reductions in the FY86 Budget," page 18, claims such changes in eligibility will save $70 million in outlays in FY86. Please provide detail on the estimated savings associated with initial examinations of veterans for care at VA facilities.

In written Question 20 on the VA's FY85 Budget last year, Chairman Simpson asked for the status of a study of the feasibility of collecting fees for user charges for VA-provided medical services by nonservice-connected beneficiaries who are not in receipt of pension. In its response, the VA indicated a contract to conduct the study was awarded to MAXIMUS, Inc., of McLean, VA and that a final report was expected in November 1984.

B. What is the status of the study and when are the results expected to be available?

C. Do you believe the results of such a study should be available before the VA proceeds any further with its proposal to limit eligibility for free VA medical care?

Answer 2.

A. The 1986 Fiscal Year budget, as submitted to Congress, does not include a cost savings specifically related to the means test. Accordingly, there are no savings attributable to reductions in initial examinations.

B & C. The VA, in 1983, was directed by OMB to undertake a study of "user fees" which was to be carried out within the context of a broader study aimed at developing a demographic profile of veteran beneficiaries. MAXIMUS, Inc., was awarded the contract to develop the beneficiary profile, to study the VA's Beneficiary Travel Program, and to conduct a review of the literature on the effects of "user fees". In June 1984, MAXIMUS presented a study questionnaire to OMB for approval. The VA was told to delete all questions relating to user fees and to confine the study of "user fees" to a review of the literature. Hence, the VA discontinued the survey aspects for a study of the possible effects of imposing user fees on veterans applying for VA health care.

Question 3.

VA Health Care In Rural Areas

Section 302 of the "Veterans' Health Care Act of 1984," P.L. 98-528, requires the Veterans Administration to carry out a nationwide and develop statistics on the number of eligible veterans living various distances from VA medical facilities and their utilization of VA health-care services during FY85.

A. What resources, both funding and FTEE, does the VA expect to expend on this study in FY85?

B. What is the status of the study and can this Committee expect a report from you on the statistics in January 1986 as required by Section 302?

C. The goal of Health Service Research is to improve the effectiveness and efficiency of the VA's health-care delivery system. What amount of the Health Services Research allocation in FY86 will fund pilot programs or other research efforts related to the improvement of health-care service delivery to veterans living in geographically remote areas?

D. Please provide a list of the above programs or research efforts, along with a funding estimate for each.

E. Please provide the funding in FY85 for each of the projects listed in the VA's written response 1G to me last year.

Answer 3.

A. **Funding for the study of veterans residing in remote geographic areas will be from the MAMOE appropriation primarily. At the present stage of the study, we are able to identify the following resource requirements. As the study proceeds, additional requirements may be identified. There is some assistance being provided by the Institute for Health Planning in Madison, Wisconsin who will be paid from consultant funds. Additionally, it may be necessary to purchase data tapes from the National Center for Health Services Reseach. A study team has been established consisting of eight members. One of the team members, a programmer, will spend full time for the next three months on the study. Another will spend approximately 25% of his time on the study for the remaining part of this year, while the rest will serve anywhere from 5% to 25% of their time for the rest of the year. Additionally, Planners from the Medical Districts and the MEDIPP Advisory Committee composed of VA field health care officials will devote some time to this study, but less than 5%. We estimate that the cost of team members' salaries and fringe benefits, which together will comprise a major component of the study's cost, will be approximately $57,000.**

B. **Good progress is being made on the study. At this point, the analysis of demography and utilization has begun. We expect that the team will brief interested Congressional staffs on the study's definitions, assumptions, and methodological constraints in the near future. The Department fully intends to meet the deadline of January 1, 1986 for Report #1 and July 1, 1986 for Report #2.**

C. As previously noted, the HSR&D Service recognizes the potential contribution research can make to improving care delivery to veterans living in geographically remote areas. Pilot or demonstration projects may require substantial resources that may be beyond HSR&D budget authority. Thus, most projects involve evaluation of existing programs or modest studies proposed by VA staff. We estimate that about $425,000 (6.4%) of the FY86 budget will be devoted to such activities. Importantly, the Region 5 HSR&D Field Program, based at VAMC Salt Lake City plans various activities relevant to improving care delivery to veterans living in geographically remote areas.

D. We project relevant Field Program activities at $200,000 in FY86 (the same level as FY85). Examples of Investigator-Initiated Research and FY86 funding estimates are listed below.

Project Example	FY86 Funding Estimate
#80-596, "Stroke Rehabilitation Using Volunteer Help" (White River Junction, VT.)	$37,000
#82-006, "Effects of Terminating Psychiatric Community Care" (White River Junction, Vt.)	22,000
#85-016 "A Community Based Model for Using Volunteers in the Rehabilitation of Older Adults with Brain Injuries" (White River Junction, Vt.)	165,000

E. The following funds were provided for each of the projects listed in our response to you last year:

Project	FY 85 Actual Funding
80-596, "Stroke Rehabilitation Using Volunteer Help (White River Junction, Vt.)	$148,700
82-006, "Effects of Terminating Psychiatric Community Care" (White River Junction, Vt.)	84,800
82-113, "Cost-effectiveness of Rural Health Centers in Providing Care for Veterans" (Togus, Maine)	0*

* The initial proposal was determined to be not suitable for support. The Service provided requested consultation funds ($850) to revise the proposal and the revised proposal currently is being reviewed.

Question 4.

Adjudication of Certain Claims

Two cases of Maine veterans who are, or have been, hampered in their efforts to establish a service connection for injury or illness incurred as a result of their participation in "secret" or "covert" intelligence operations while in service have recently been brought to my attention. These cases prompt me to inquire about the VA's present procedures for handling such claims.

A. What is the caseload, yearly, in which the VA, while determining the validity of a claim for service connection must solicite corroborating information from intelligence functions within the Department of Defense as to a veteran's service record?

B. Does the VA presently have a Memorandum of Intent (MOI), Interagency Agreement, or any other written cooperative working agreement with the Department of Defense or a specific service as to procedures by which sensitive materials relevant to VA adjudication proceedings can be considered? If so, please provide that agreement.

C. Would the VA support, in the absence of such a working arrangement, in instances where the Federal government retains possession of the records necessary to disapprove a claim for a service connected disability based on service in "covert" or intelligence operations, an assumption in favor of the veteran unless the government proves otherwise? Please provide a cost estimation, to the extent possible for such an assumption.

Answer 4.

We are aware of only one case from Maine, and our initial review of it does not support the veteran's contention that he was involved in a covert intelligence operation. We have established this veteran's entitlement to benefits based on other evidence in his claims file. As this is the only case of which we are aware, we do not believe that inability to secure classified records is a pervasive problem. However, we have contacted the Department of Defense, and they assure us of their cooperation in securing the necessary information from the military records of veterans engaged in intelligence activities. No written agreement exists since we feel that the number of such cases is very small and that current cooperative measures with the Department of Defense are sufficient to secure the evidence needed to adjudicate claims for benefits, regardless of the circumstances of the veteran's service. We would be opposed to any changes in the generally applicable claims procedures.

We currently resolve reasonable doubts in favor of claimants. To make an assumption in favor of the veteran, without evidence to support the veteran's claim, would be directly contrary to the procedures used in all other cases. We do not believe that this type of exception is warranted based on participation in intelligence operations.

Since we have no indication of the numbers which would be involved, we would be unable to provide a cost estimate for any legislated assumptions or presumptions applicable to veterans who served in sensitive military occupations.

Question 5.

Small Business Administration (SBA)

The President's FY86 Budget proposes to terminate Small Business Administration (SBA) programs, including directed and guaranteed business and disaster loans. It proposes to create a new Administration for Enterprise Development and Opportunity in the Department of Commerce.

A. Do you have any indication from either the White House or the Department of Commerce that veterans will be given any special consideration in such a new Administration?

B. Please provide the portion of SBA direct and guaranteed loans in FY85 that are estimated will be secured by veterans.

C. Do you support the President's proposal to eliminate SBA?

Answer 5.

A. **The scope, authorities and responsibilities for the proposed new Administration for Enterprise Development and Opportunity in the Department of Commerce have not been reviewed by the Veterans Administration.**

B. **The following information on SBA direct and guaranteed loans to veterans in FY 1984 and the first quarter of FY 1985 was provided to the Veterans Administration by the Office of Veterans Affairs, U.S. Small Business Administration (SBA). SBA advises that they do not have projections or estimates for the remaining quarters of FY 1985.**

C. **As a member of this Administration, I support the President's efforts to consolidate and streamline Federal functions to achieve more efficient and effective program delivery. I have not specifically participated in the decisions pertaining to the President's proposal for SBA.**

SBA VETERAN LOAN STATISTICS
FISCAL YEAR 1984
October 1, 1983 - September 30, 1984

Total Agency Loans:		
Direct	2,234	$ 144,210,992
Guaranty	14,315	$2,855,675,973
Total Loans to Vietnam-era Veterans:		(2.771/$367,397,000)
Direct	630	$ 38,895,000
Guaranty	2,129	$ 326,439,000
Other	12	$ 2,063,000
Total Loans to Other Veterans:		(2,366/$429,096,000)
Direct	203	$ 13,731,000
Guaranty	2,158	$ 414,680,000
Other	5	$ 685,000

Distribution of PL 97-72 Loan Funds

FY 1983	102	$ 6.4 million
FY 1984	294	$19.7 million

(These figures are includedin the overall loan figures above but are itemized here to show how the Vietnam-era and Disabled Veteran Loan Fund has been expended.)

SBA VETERAN LOAN STATISTICS
FISCAL YEAR 1985
October 1, 1984 - December 31,1984

Total Agency Loans:

Direct	545	$ 33,648,498
Guaranty	3,906	$ 585,113,075

Total Loans to Vietnam-era Veterans: (473/$65,002)

Direct	64	$ 2,927
Guaranty	407	$ 61,857
Other	2	$ 218

Total Loans to Other Veterans: (486/$91,986)

Direct	38	$ 2,321
Guaranty	448	$ 89,665
Other	0	$ 0

Distribution of PL 97-72 Loan Funds:

FY 1983	102	$ 6.4 million
FY 1984	294	$19.7 million*
FY 1985	47	$ 2,555,200

(FY 85 thru December 31, 1984)

(These figures are included in the overall loan figures above but are itemized here to show how the Vietnam-era and Disabled Veteran Loan Fund has been expended.)

*Year end figure adjusted

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Office of Veterans Affairs
U.S. Small Business Admin.
1441 L Street N.W. - Room 500G
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Chairman MURKOWSKI. The service organizations will join us now: The American Legion, Mr. Paul Egan, Deputy Director of the National Legislative Commission; Mr. John Sommer, Deputy Director of Veterans Affairs Rehabilitation Division. Our third witness will be Mr. Donald H. Schwab, representing the Veterans of Foreign Wars of the United States. I am told that the others will come up later.

Thank you. I want to apologize for the time lapse that has occurred since you came in and we called the meeting to order. We do appreciate your patience. Hopefully, the testimony and questions and answers were somewhat enlightening. In any event, we are honored by your presence, and look forward to your testimony. I ask that you proceed according to whatever agreement you may have had. I do not know whether it is alphabetical, but The American Legion will go first.

TESTIMONY OF A PANEL OF REPRESENTATIVES OF VETERANS' ORGANIZATIONS CONSISTING OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, ACCOMPANIED BY JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION; AND DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, ACCOMPANIED BY FEDERICO JUARBE, DIRECTOR OF NATIONAL VETERANS' SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. EGAN. First of all, we accept your apologies. And second of all, we too want to welcome you as chairman of this committee. We have a paucity of time available to us, so John Sommer of our Veterans' Affairs and Rehabilitation Division will summarize for us.

Chairman MURKOWSKI. Thank you.

Mr. SOMMER. Mr. Chairman, The American Legion certainly appreciates this opportunity to summarize its views on the proposed VA budget for fiscal year 1986. Our comments and concerns are elaborated in our full statement. We must say that The American Legion does not feel that the proposed——

Chairman MURKOWSKI. Your full statement will be entered into the record.

Mr. SOMMER. Thank you, sir.

We must say that The American Legion does not feel that the proposed funding levels are satisfactory to carry out all of the programs administered by VA. The portion of the total Federal budget consumed by veterans' programs has been steadily shrinking over the past 10 years from a full 5 percent in fiscal year 1975 to 2.7 percent in the current fiscal year.

Thus, it cannot be said that veterans are receiving more than their fair share of total Federal dollars when in fact the contrary is true. In addressing the legislative initiatives contained in the budget message, we are pleased to see a proposed 4.1-percent COLA in compensation effective December 1.

However, the Legion is opposed to those proposals relating to the home loan program, and the repeal of authority for VA education loans. We are also opposed to third-party reimbursement and the implementation of a means test for non-service-connected veterans seeking VA medical care.

We do not feel that these proposals would cost effectively accomplish the purpose for which they have been proposed.

The section of the budget message relating to the Department of Veterans' Benefits provides funding to accomplish a plan, that has been discussed previously, by OMB and that VA is beginning action on which would consolidate DVB benefit and support activities into three regional centers.

The proposed concept would eliminate direct service to veterans by denying them the opportunity to present claims in person with the assistance of a veterans' service organization. The individual veteran needs and deserves this opportunity.

The American Legion is totally opposed to the planned consolidation and reorganization as we consider it neither reasonable nor practical.

I am sorry that Senator Cranston is not here because The American Legion would like him to know that we deeply appreciate his prompt reaction to the Administrator's correspondence dated February 1 wherein the proposed plan for the reorganization of DVB was only superficially addressed, and little justification for the move was given.

We are well aware that section 210(b)(2) of the title was enacted following the "midnight massacre" of March 1981 when OMB announced that DVB was to lose over 1,600 employees, and the proposal surfaced to consolidate the majority of the operations of the VA regional office into a maximum of three or a minimum of one centralized location.

Fortunately, that proposal was short lived, and we sincerely hope that the proposal now under consideration will meet that same fate.

In the funding for the Department of Medicine and Surgery, we have several concerns. The proposed medical workloads for fiscal year 1986 show no change in inpatients treated in VA hospitals which is projected at $1.4 million for the year.

The maintenance of average operating beds in the VA system reflects a loss of 1,000 acute care beds which is deeply disturbing to us. Another extreme concern is the absence of specific reference in the budget to important medical programs such as inpatient PTSD units, hospital based home care, adult daycare centers, and geriatric evaluation units.

Other areas of concern are the proposed decreases in medical and prosthetic research, no funds for the expansion of the GRECC program, a reduction of funds for State home grants, and a decrease in funding for medical construction.

Mr. Chairman, may we reiterate that although VA spending has increased over the past several years, the portion of the total Federal budget consumed by VA has decreased. And the increases in dollar amounts have been carefully measured, and in no way constitute a budget out of control.

The GI bill education costs, for example, were $4.6 billion in 1975, and dropped to $1.4 billion in 1984. Against that background, other education assistance programs operated by the Department of Education have increased enormously.

In another example, VA health-care spending between 1975 and 1985 rose from $3.7 billion to $8.8 billion, an increase of 138 percent. On the other hand, Medicare spending over the same period rose from $12.9 billion to $62 billion, an increase of 380 percent.

It is mistaken to hold out the VA budget for cuts on the dubious assumption that fairness somehow dictates that VA must contribute even more than it already has. Given the restraint in VA spending over the past 10 years by contrast with the cost of other programs, the VA budget has been a model of frugality, not one needing further restraint beyond what has been accomplished.

That completes my summary. Thank you very much.

Chairman MURKOWSKI. Thank you very much, Mr. Sommer.

[The prepared statement of Paul S. Egan, deputy director, National Legislative Commission, and John F. Sommer, Jr., deputy director, National Veterans Affairs and Rehabilitation Commission, The American Legion, follow:]

PREPARED STATEMENT OF PAUL S. EGAN, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, AND JOHN F. SOMMER, JR., DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

Mr. Chairman and Members of the Committee:

The American Legion appreciates the opportunity to present its views, following an initial appraisal of the Administration's proposed Budget for the Veterans Administration for Fiscal Year 1986.

It must be said at the outset that we are aware the Administration is seriously concerned about the ominous budgetary deficit that faces the Federal Government. Veterans have shared that concern and during the immediate three previous fiscal years have acceded to reductions in veterans programs that have amounted to, on the whole, more than $500 million. Most of these adjustments, when proposed, were accepted by The American Legion, because we represent the nation's veteran population, and veterans are responsible citizens. When all entitlement programs were being modified, we believed that veterans must do their share - and we have done just that.

Additionally, the portion of the total Federal Budget consumed by veterans programs has been steadily shrinking over the past ten years. In FY 1975 the VA Budget represented a full 5 percent of the total Federal expenditures; in FY 1981 - 3.2 percent, and in FY 1985 - 2.7 percent. Thus it cannot be said that veterans are receiving more than their fair share of total Federal dollars when in fact just the contrary is true.

The American Legion believes that any further reductions in funding for veterans programs would prove seriously harmful to the most needy and deserving beneficiaries of programs administered by the Veterans Administration.

For Fiscal Year 1986, the President has proposed for the Veterans Administration, Budget Authority of almost $27.110 billion, down $123.6 million from FY 1985, and Budget Outlays of nearly $26.729 billion, down over $82.3 million from FY 1985.

The American Legion stands for full funding for veterans programs; by which we mean there should be provision of such funds as are necessary to effectively carry out the programs that have been established by Congress. We support all those programs. Each of them had a purpose when enacted, and each was adequately justified as meeting a legitimate need of the veteran population. We are not aware of any programs at present that are superfluous or redundant; and therefore we support all veterans assistance programs that are now functioning.

The fact is, Mr. Chairman, The American Legion does not feel the proposed funding levels for FY 1986 are satisfactory to effectively carry out all of the programs administered by the Veterans Administration. The budget proposal provides no overall increase in spending, and contains initiatives that would adversely affect thousands of America's veterans, their dependents and survivors.

Before providing comment on several specific budget items, which will be done in reference to the departments of the VA that administer them, we shall first address the legislative proposals set forth in the Budget Message.

LEGISLATIVE INITIATIVES

# The Administration recommends a cost-of-living adjustment of 4.1 percent in compensation to be effective December 1, 1985. It is the position of The American Legion that these COLAs should be at least consistent with increases in the Consumer Price Index. The proposed 4.1 percent increase in benefits for the service-disabled, who are the most deserving of all Federal beneficiaries, is consistent with the current rate of inflation.

# An increase in the loan origination fee from 1 percent to 5 percent on all guaranteed and vendee loans is proposed. The American Legion is opposed to this increase. In practical effect, it would eliminate the advantage of enabling a veteran to purchase a home with no down payment.

Another loan guaranty proposal would allow for borrower/lender negotiated rates on guaranteed and vendee loans; and terminate the Administrator's authority to set interest rates. We oppose this action, as it would drive interest rates up, and put veterans out of the housing market.

The third initiative relating to the home loan program would repeal transfer authority from the Direct Loan Revolving Fund to the Loan Guaranty Revolving Fund, and the Legion opposes this move because over the past several years foreclosures resulting in part from high unemployment have depleted the Loan Guaranty Revolving Fund, and the ability to transfer funds from the Direct Loan

Revolving Fund has kept that fund solvent.

# Proposed legislation would repeal the authority that permits VA to make education loans. Although an earlier cost-savings measure, the Omnibus Budget Reconciliation Act of 1981 (PL 97-35), limited the number of individuals eligible for VA education loans, those who retain eligibility and who depend upon these loans could be forced to discontinue their program of education or training. Thus, we oppose this initiative.

# Another proposal would effect reimbursement from third party insurance carriers, for cost of medical care and treatment to veterans with nonservice-connected disabilities, effective October 1, 1985. The American Legion is mandated to oppose third party reimbursement for several reasons, the primary one being that in essence veterans would be paying for their VA medical care through health insurance premiums. If third party reimbursement were implemented the VA health care program would be changed in its essential nature from a benefit to a cost-sharing medical plan. The American Legion believes if that were to happen, we would find it difficult to defend the program against vouchering or mainstreaming. The projected savings resulting from third party reimbursement is $65 million, and quite frankly, we fail to see how that could be an accurate figure. We have heard statements made by VA officials during Congressional hearings to the effect that the administrative costs necessary to implement the mechanism for collection of insurance payments would probably exceed the costs that are recovered. Such reasoning seems logical when considering

the majority of nonservice-connected veterans using the VA system are probably not covered by insurance, and that complicated problems involving cost formulas, quality controls and distribution of services would have to be resolved before third party reimbursement legislation could be implemented.

# The Administration is also proposing legislation to establish income criteria for medical care eligibility (means test) for nonservice-connected disabled veterans regardless of age. This proposal would, among other things, rescind 38 USC 610(a)(6), a provision of PL 91-500 authorizing that the Administrator, within the limits of Veterans Administration facilities, may furnish hospital care or nursing home care which the Administrator determines is needed to any veteran for a nonservice-connected disability if such veteran is sixty-five years of age or older. It would also rescind section 401 of PL 96-330, a provision calling for VA to require evidence of inability to defray necessary expenses from nonservice-connected veterans under age 65, which has not been implemented as of this time. It has not been implemented because of problems as between VA and OMB in developing a testing formula that would be fair to all parties, especially the veteran, and that would not create administrative burdens that would outweigh the monetary gains to be achieved. Whether or not it remains true presently we do not know, but at last report we were informed by VA there would be no additional FTEE provided to the VA medical centers to administer the means test, if implemented.

The American Legion would not support a means test for nonservice-connected veterans regardless of age. We believe it would prove to be ineffective because available information indicates that most of the veterans that use the VA medical care system are old, sick and poor. If forced out of the VA system these veterans would have to resort to Medicare, Medicaid, or to other publicly supported institutions.

One of the primary reasons for the implementation of subsection 610(a)(6) of the title was the fact that nearly every veteran age 65 and up is eligible for Medicare. The legislative history of PL 91-500 shows that at the time the legislation was being considered, the cost of the provision of treatment under Medicare was higher than the cost of care by VA. It was estimated that savings to the Federal Government would exceed $8 million during FY 1971 because veterans were treated by VA and not under Medicare. Current available figures reflect that the average daily cost of treatment in a VA facility is still less than the average daily cost of care provided through Medicare.

The implication that the VA system is crowded with affluent veterans is a myth. It is the earnest suggestion of The American Legion that before any consideration is given to this proposed legislation, the Committee should require from VA an updated profile of the current patient population of the VA system. If, as we believe, such a profile demonstrates that the veterans using the system are overwhelmingly old and poor, then the question has to be answered, why establish another administrative mechanism that will accomplish nothing.

DEPARTMENT OF VETERANS BENEFITS

The direct benefit programs administered by VA through the Department of Veterans Benefits will consume 59.3% of the total VA Budget. These are, for the most part, the entitlement programs that must be funded, and they are meeting the real needs of the veteran population they are intended to serve.

These benefits are currently administered through 59 regional offices and, Mr. Chairman, as you are well aware, the Office of Management and Budget has proposed, and VA is beginning action on, a planned reorganization and consolidation of field office functions of the Department of Veterans Benefits. The plan is to consolidate DVB benefit and support activities into three regional centers. Activities included would be adjudication of compensation, pension and education claims; loan processing, and support services, including administrative, finance, and personnel functions. The only services that would remain at the regional offices are veterans benefits counselors, vocational rehabilitation and counseling personnel, compliance survey, and some loan guaranty activities.

The proposed consolidation would be carried out over three fiscal years - 1986 through 1988 - at a cost of $85 million.

This proposal is reminiscent of the "midnight massacre" of March 1981, when OMB announced that DVB was to lose over 1600 employees and a proposal surfaced to consolidate the majority of the operations of the VA regional offices into one or a maximum of three centralized locations. Fortunately, that proposal was short-lived.

Mr. Chairman, the proposed concept would eliminate direct service to veterans who are attempting to develop claims for benefits by denying the claimant the opportunity to present his or her claim in person, and with the assistance of a veterans service organization. The individual veteran needs and deserves this opportunity.

The American Legion is totally opposed to the planned consolidation and reorganization, as we consider it as neither reasonable nor practical.

An additional, but congruent matter of concern is the proposed reduction of 624 FTEE in DVB. Although this loss of personnel is designated as "savings through consolidation" in the Budget Message, it is consistent with reductions of FTEE in the Department of Veterans Benefits over the past several years.

The proposed reduction would bring average employment in DVB down to 12,894. This loss is superimposed on previous reductions, through FY 1985, of 4,558 FTEE since FY 1979. We must advise the Committee that we are concerned about the effect of these losses on delivery of services to VA beneficiaries. The timely delivery of benefits to veterans, their dependents and survivors is an important responsibility of the Department of Veterans Benefits, and the quality of work performed by personnel assigned to DVB, determines to a great extent whether beneficiaries do in fact receive the benefits to which they are entitled by law. Consistent and persistent reduction of personnel will inevitably impact on the ability of DVB staff to complete action on cases and disburse benefits. The American Legion's concern is projected from the standpoint that VA beneficiaries are either the service-disabled, their survivors, or the aged and infirm seeking pensions. All are persons who very much need the benefits they are seeking, many on an urgent basis.

Aside from the proposed consolidation, VA management attributes the reduction to declining work loads and management actions to reduce overhead and increase productivity. We respond that although the case load is in fact declining, the complexity of claims has increased due in part to issues such as the effects of exposure to Agent Orange and radiation, and the pathology of Post-Traumatic Stress Disorder, thus requiring more man hours per case. The Legion is certainly supportive of economy of personnel in management, and maximum productivity by all Federal employees. However, a certain minimum of personnel is needed to properly process cases, without delay-causing errors that have to be corrected; and productivity can only be used as a relative guide when considering the volume of paper work that must be done in the processing of a single case for award of benefits.

We believe the Committee should press for precise data and information from VA before effecting further loss of field personnel in DVB, and we strongly recommend active oversight during the year to ensure prompt delivery of benefits.

DEPARTMENT OF MEDICINE AND SURGERY

There is no question that the most sensitive area of the Budget for the Veterans Administration is the medical care program. This is because, unlike the entitlement programs that are statutory in nature, the strength and efficacy of the medical care program depends directly on the allocation of funds by Congress.

The Administration proposes more than $9 billion for medical programs in FY 1986, representing 35.5% of the total VA Budget. Although this is a projected increase of $236 million over FY 1985, much of this is consumed by normal payroll increases and inflation.

We note that the average employment in DM&S will increase in FY 1986, by 199 to 192,048. However, upon close examination of the figures for average employment we see included therein a reduction of 889 FTEE in existing medical centers, and the loss of 1,916 FTEE due to Government-wide and management reductions. The American Legion is opposed to any reduction that would impact on health care professionals. Based on our monitoring of the Department of Medicine and Surgery through site visits by Legion Field Representatives to more than 65 medical centers each year, we can attest that every one of the personnel assigned are needed. The staff to patient ratio in tertiary VA medical centers is lower than in private sector hospitals, and much lower than will be found in university hospitals.

The proposed medical work loads for FY 1986 reflect no change in the number of inpatients treated in VA hospitals, which is projected at 1.4 million for the year. There is an allowance for an increase of 112,000 outpatient visits to almost 18.8 million, which we consider badly needed. It is estimated that over 21,000 veterans a month are turned away from outpatient clinics.

The maintenance of average operating beds in the VA system reflects a loss of 1,000 acute care beds and 100 domiciliary beds, and an increase of 700 nursing home beds for a net loss of 400 beds. The loss of 1,000 acute care beds is deeply disturbing to The American Legion, particularly when considering the fact that VA faces the prospect of 7 million World War II veterans passing age 65 by 1990.

We have offered precautionary comments over the past several years, that in our judgment there should be no further reduction of acute care beds within the system. However, since FY 1981 3,500 acute care beds have been eliminated - and that does not include the decrease of 1,000 beds proposed for FY 1986. This is a particularly bad time to be eliminating acute care beds, when aging veterans are experiencing more catastrophic illnesses. Older persons ordinarily require care for an acute episode before passing to the need for long-term care. Thus, while the need for more long-term care beds in the system is clearly demonstrable, that need by itself does not connote a decreasing need for acute care beds. The Veterans Administration must maintain a substantial number of acute care beds if it is to retain its ability to treat the full mix of treatment needs required of it by its primary mission, and its ability to fulfill the agency's latest assigned mission as the principal contingency back-up to the Armed Services medical programs in case of an outbreak of hostilities.

We do approve of the proposed increase of 700 nursing care beds, to 11,500. Nursing Home Care Units in the VA system are always used to capacity, and most of them have waiting lists. A consistent increase in nursing care beds is strongly indicated.

Of extreme concern to The American Legion is the absence of any reference whatsoever in the Budget Message to several important medical programs, beginning with inpatient Post-Traumatic Stress Disorder units. PL 98-528, the Veterans Administration Health Care Amendments of 1984, was enacted in October, and provides for badly needed improvements in the diagnosis and treatment of PTSD. Provisions include authorization for the Chief Medical Director to designate special programs for the treatment of PTSD; a requirement that the CMD establish a Special Committee on PTSD in the Department of Medicine and Surgery; a provision that directs the CMD to establish and operate a National Center on PTSD to conduct and promote research and training on the diagnosis and treatment of veterans with PTSD, and to serve as a resource center for coordination and exchange of information on research and training with respect to the disorder. The law also requires the Administrator to submit to the Veterans Affairs Committees, detailed reports on, among other things, a description of resources allocated to each PTSD program, and an assessment of the VA's capacity to meet the needs of certain veterans for PTSD diagnosis and treatment and any plans, including costs, of increasing that capacity. The first report is to be submitted not later than March 1, 1985. Not later than February 1, 1986, and February 1 of each year for the following three years thereafter, the Administrator is to submit to the Committees a report updating those previously submitted.

With respect to the portions of these reports relating to the allocation of resources for PTSD programs, treatment and research, the first report is to include information with respect to allocations made for FY 1986 and expenditures for each prior year. As stated earlier, we find no reference to any funds being allocated to the treatment of PTSD for FY 1986 in the Budget Message.

In addition, The American Legion has strongly advocated the continued development of innovative treatment modalities that will relieve pressure on acute care sections of VA medical centers. Here we are talking about such things as Ambulatory Surgery, Hospital Based Home Care, Adult Day Care Centers, and Geriatric Evaluation Units. We find no funding allocated to these programs in the proposed Budget. We are also fully in support of the development of the hospice and respite care movement within VA, and no funding is provided for these programs.

The American Legion considers all of these innovative modalities as part of an integrated health care program, and feels that funding must be provided for each of them.

Medical and Prosthetic Research

A decrease of $5 million, down to $187 million, in research funds is projected for FY 1986, and this is not acceptable to The American Legion.

The Medical and Prosthetic Research Program in the Department of Medicine and Surgery is a matter of special concern to us. This is because we are keenly aware of the importance of research in the triad of the VA health care program: clinical care, education of health manpower, and research. None of the three elements can thrive without the presence of the other two. It is a known fact that VA cannot continue to provide high quality medical care to veterans without a strongly funded research program. Much of the research in which VA engages is basic research that is advantageous not only to veterans, but which advances medical science and is of direct benefit to all mankind.

Equally important is the fact that a strong and viable research program ensures the recruitment and retention of high quality physicians into VA service. This fact was proven during recent years, when serious underfunding of VA research led to the loss of many good physicians who took employment elsewhere so they could pursue research. We trust the Congress will not let such a situation develop again.

The decrease of $5 million is alarming. Also projected is a loss of 157 research personnel which would bring the systemwide total down to 4,348. We do not know how these reductions will be accomplished, but we are extremely concerned, because we see a need not for a reduction, but rather for an increase of available personnel for the research activities. The Federal Government could not spend any of its funds any more wisely than on a vigorous and viable VA research program, that benefits the entire American people. The increase in research funds for FY 1985 was encouraging. However, the proposed reduction may be viewed as a serious threat to the program.

Geriatric Research Education and Clinical Centers (GRECCs)

We are concerned at the fact that there are no funds in the VA Budget for further expansion of the GRECC program.

Public Law 96-330, approved August 26, 1980, authorized the establishment of seven GRECCs in addition to the eight then functioning. In FY 1984, VA requested and received funding to establish two additional GRECCs. At that time it was explained to us that VA would request funding for two additional GRECCs each year until the seven authorized were operating, for a total of 15, as authorized by PL 96-330.

Additionally, a provision contained in PL 98-528 made permanent the authorization of appropriations to support the research and education activities of the GRECC program in Fiscal Years 1985 and beyond.

The fact that in FY 1986 there is again no proposed funding for expansion of the program is discouraging. We believe that any further delay in establishing the authorized GRECCs will be unfortunate. These centers of excellence are doing extremely valuable work in all three fields of clinical care, education of health professionals in aspects of geriatric medicine, and in basic research on such conditions as various forms of cancer and Alzheimer's Disease. It is obvious that with the nation's aging population, and increased longevity, there is a desperate need for more knowledge about Alzheimer's Disease. With encouragement and needed funding there is a possibility for VA research to lead the field in this particular disease, before it becomes a health problem of epidemic proportions.

We would appreciate the Committee's consideration of adjusting the VA Budget to include funds for, and instructions to VA to proceed to establish another one or two GRECCs during FY 1986.

Grants for Construction of State Extended Care Facilities

The Budget Message proposes a reduction of $13 million, down to $22 million for grants for construction of State Extended Care Facilities.

The American Legion is very much aware that the services provided by State Homes have greatly reduced the burden that otherwise would have been borne by the Veterans Administration, and when considering the current efforts to reduce Federal spending, the role of the State Homes becomes even more significant.

The FY 1986 request will provide for four projects which will produce 450 additional nursing home beds, and 126 convertible (domiciliary/nursing home) beds. Additionally, these resources will support one life safety project and eight remodeling projects.

However, we are informed there is now a backlog of 66 projects representing requests for grants of $165 million - and the list is growing almost daily. What this means is that if a State submits a request for a grant for funding of a project today, it may receive funds five to six years in the future.

The proposed decrease of $13 million translates into funding for fewer requests in FY 1986. As we move into the period of an aging veteran population that will be with the nation for the foreseeable future, the States can be of major assistance to the

Federal Government in caring for this population through State Homes and extended care facilities. However, in order to materially ease the pressure on the resources of VA, adequate funding must be provided to the States so that proposed projects may be completed.

The American Legion does not feel that the proposed $22 million is sufficient for the funding of grants for construction of State Homes, and this position is based upon the backlog of requests. Many States are moving very positively to make provision for their aging veteran populations, a fact that is most commendable. However, it deserves the full support and encouragement of the Federal Government. This program is a most cost-effective way for the Federal Government to meet its obligation to veterans.

Grants to the Republic of the Philippines

The Budget proposal provides a grant of $500 thousand to the Veterans Memorial Hospital in Manila. This grant has been made by the United States consistently since the end of WW II. The Veterans Memorial Hospital cares for many Filipino veterans who served in the Allied cause during WW II. There is certainly an obligation by this country to continue to show our gratitude and concern for them. The American Legion has always supported this grant, and continues to do so.

MEDICAL CONSTRUCTION

In the Administration's Budget, the medical construction program is recommended for a reduction of $154.9 million down to $712.9 million, for FY 1986. And that figure includes $160 million in prior budget authority that is being reprogrammed from the major working reserve.

We realize this is the second largest construction budget in VA's history, the largest being in the current fiscal year. However, we question the wisdom of reducing the funding for medical construction when the capital plant of the VA health care system is deteriorating. The reasons for this deterioration are manifold; one of them being serious underfunding of this program for several years until recently. This means VA is playing catch-up with its capital plant renovation and replacement program. The facilities have aged more while nothing was being done, and costs have escalated. It has been a losing proposition all around. Finally, the Government has been trying to make up for lost time, and it is costing a lot of money, but it is still a good investment. As we have said many times, the capital plant of the VA system is a multi-billion dollar investment by the Federal Government, and it must not be allowed to deteriorate.

We have preliminarily reviewed the replacement and renovation projects scheduled for FY 1986, and based on the reports of our Field Representatives who make site visits to all of these facilities, we can assure the Committee all of the work scheduled is needed, and much of it is long overdue.

We are pleased to see funding provided for work on a clinical addition, renovation, parking and a 240-bed Nursing Home Care Unit in Philadelphia; and for replacement and modernization at the VAMC Houston.

We do have two particular areas of concern we wish to mention.

First is the issue of the replacement hospital at Baltimore. The need for a replacement hospital in Baltimore has long been established, and, in fact, construction had begun when the President included the funding for this construction in a recession message in 1981.

In August 1984 VA requested a $2 million increase in the Advance Planning Fund in the FY 1985 Budget request for use in determining the most appropriate approach to modernizing the medical centers at Loch Raven and Fort Howard. As a result of that request, Congress provided the $2 million and directed VA to add the alternative of a new replacement medical center to the modernization of the two facilities. A planning report on this is scheduled for completion on April 1, and it will reportedly recommend the best course of action. Regardless of the recommendations contained in the report, we have been told that implementation of any proposals would not be possible until FY 1988 or 1989.

The American Legion strongly recommends a replacement hospital in Baltimore. We have seen evidence where veterans who could have benefitted from inpatient treatment at VAMC Baltimore, have been placed in ambulatory care programs in order to meet, as well as possible, their medical needs. We understand that the medical center has been forced to admit only those veterans suffering from the most severe acute illnesses, for which hospitalization is absolutely necessary. In addition, we have learned that due to constraints on resources and space, major elective surgery cases have been delayed. The American Legion feels that a replacement hospital needs to be built and should be built. We hope the Committee will give this serious consideration.

Our second concern is the 60-bed nursing home that was proposed for construction at VAMC Providence, Rhode Island. At the request of the Chairman, Subcommittee on HUD - Independent Agencies, Senate Committee on Appropriations, the General Accounting Office issued a report dated May 15, 1984, subject of which is titled "VA Justification for Two Nursing Home Care Construction Projects in its Fiscal Year 1985 Budget Request." The report states that the project at the Providence VAMC does not appear to be needed. The report goes on to say that VA did not adequately consider local needs and resources which indicate that the Providence area will have an ample supply of community and State Home beds to meet veterans nursing home needs in 1990. According to the report, on May 11, 1984, the Acting Chief Medical Director advised GAO that he had recommended to the Administrator that the project be deleted from the VA's Fiscal Year 1985 Budget request.

The American Legion disagrees categorically with the information released by the General Accounting Office that the VA assessment of the need for nursing care at Providence was not sustainable. We have been in frequent communication with the Rhode Island American Legion, and our information from that organization is contrary to the GAO Report.

A site visit report by an American Legion Field Representative covering the period September 5-11, 1984, states in its conclusions that the needs of the aging veteran have been brushed aside by the

Providence VA Medical Center. The report goes on to say that "the nursing home needs of the veterans within the Primary Service Area (PSA) of the medical center cannot be met today. If a 60-bed NHCU was opened today on facility grounds, it would be at full occupancy within a month. During the course of this survey, 55 veterans were placed in 28 contract nursing homes from this facility. This did not include 30 placements from the New Bedford area. Also, the waiting list was estimated at between 20-25. Exact figures regarding the waiting list were not revealed to this surveyor." The report continues by stating that no further placement could be done at that time because there was no funding available since it was the end of the fiscal year. The waiting period for veterans was reported by VA staff as only two to three weeks, but the Commandant of the Bristol State Home stated his waiting list included approximately 60 applicants and the waiting period was between six to eight months. The surveyor felt as a result that the figures offered by VA staff were suspect.

Statistics from DM&S show that in FY 1983, 22,340 veterans resided within the Providence PSA between ages 65-74, and 6,886 were age 75 and older. It is estimated in FY 1990, 39,749 veterans will be between the ages of 65-74, and 10,824 will be age 75 and older.

Figures obtained from the Rhode Island Department of Health and used by GAO in support of its report reflect that providers plan to develop 1,098 additional nursing beds within the next five years either through expansion or new construction. The Providence

Medical Center Director advised our Field Representative that it is certain that by the Spring of 1985, 432 additional beds will become operational and quite likely that 120 more beds will be developed by late 1985. It must be pointed out that if in fact the proposed 552 beds were constructed in the private sector, they would be for use of all citizens of Rhode Island, not just veterans. However, we seriously question the proposed number of beds, and particularly those proposed for 1985. As of September 11, 1984, the date on which our Field Representative left Providence, not one construction project had started within the State.

Recommendation No. 1 contained in the Field Service Report recommends that funding for construction of a 60-bed NHCU be approved, and that the project be given top priority.

Mr. Chairman, on the basis of the Field Service Report and the information provided to us by the Rhode Island American Legion, we wish to reiterate at this time the support of the National Organization of The American Legion for the construction of a Nursing Home Care Unit at VAMC Providence. We are satisfied the unit is needed to provide care for veterans in the Primary Service Area of that VAMC. We believe the data assembled by the General Accounting Office is not accurate or correct, and does not demonstrate an understanding of the needs and problems of the aging veteran population of the Providence area. Our recommendation to the Committee is that funding for the unit be included in the FY 1986 Budget.

Beyond these two special areas of attention, we wish only to reiterate our concern regarding the wisdom of the proposed reduction in medical construction funding at a time when VA is playing catch-up with its capital plant renovation program.

As we have previously stated to the Committee, in a sense the expenditures in this budget area are capital investments, and should not even be included in the total Federal funding that is leading to such high deficits. There is a school of thought in the Congress itself that the capital investments and expenditures of the Federal Government should be identified separately as they are in most business operations.

DEPARTMENT OF MEMORIAL AFFAIRS

The funding request for the Department of Memorial Affairs reflects a slight increase of $97 thousand to $44,269 million for FY 1986. An additional $18.9 million is identified for cemetery construction projects which is up $1.8 million from FY 1985. The American Legion feels that this funding appears adequate. We totally support the construction program that is underway, and which includes the Ft. Mitchell National Cemetery, scheduled to open in the Fall of 1986; the development of 13,000 gravesites and construction of an administration building at Withlacoochee, Florida; and the proposed land purchase in Northern California. We continue to work with the Department of Memorial Affairs in attempting to acquire land for the expansion of existing national cemeteries.

The total Memorial Affairs program, we believe, is progressing in a satisfactory manner. It is the perception of the Legion that the program has improved immeasurably since it was placed under VA jurisdiction. We commend the progress that is being made, and trust that the Congress will continue to support VA's plans with the modest funding needed for this program.

ECONOMIC CONCERNS

Mr. Chairman, The American Legion also has several concerns regarding programs for veterans operated by agencies other than the VA. While some of these programs may not fall within the strict parameters of this Committee's jurisdiction, they nevertheless deserve this Committee's attention.

Within the Department of Labor there are a variety of programs for veterans operated under the direction of the Assistant Secretary of Labor for Veterans Employment and Training (ASVET). The American Legion is generally pleased that the proposed FY 1986 budget for the operation of DoL programs contains no significant cuts. However, it must be understood that any cuts in these programs will be felt more deeply because these programs are already operating on a bare bones budget.

For example, an 8 percent cut in travel funding for the Veterans Employment Service, as contemplated in the FY 1986 budget, can be expected to significantly hamper the efforts of State Directors of Veterans Employment in the execution of their outreach responsibilities. Another example is the cut in funding for the veterans portion of the Job Training Partnership Act (part IV. c.) from $9.7 million in FY 1985 to $7.7 million as proposed for FY 1986. In this case, already limited funding for those participating grantees in the States is having an affect on the number and quality of services provided. Further cuts will have a predictable and negative impact.

In another area, the FY 1986 budget contemplates unhitching State Employment Security Agencies, otherwise known as the job service, from the Federal Government altogether by FY 1988. Given the fact that State and Regional Directors of the Veterans Employment Service as well as Local Veterans Employment Representatives and Disabled Veterans Outreach Program Specialists all base their operations in local job service offices, a proposal allowing the devolution of the job service has to be viewed with considerable foreboding. Apart from the rationale used to support this proposal, the most obvious and immediate question that remains unanswered is, what will become of employment services to veterans if the proposal is implemented. In the absence of any clear and convincing assurances that these services for veterans will continue as an ongoing Federal obligation to veterans economic readjustment, The American Legion must oppose this proposal.

In another agency, the Small Business Administration (SBA), the FY 1986 budget proposes complete disolution. Regardless of the reasoning behind this proposal, it is important to recognize that it is only in the last few years that veterans have been able to benefit from programs long on the books.

It is only recently that SBA has been providing veterans with the special consideration in their applications for loan guarantees as provided by law for many years. After having been ignored for so long, this law has finally been translated into positive gains that have been good for the general economy, the veterans served and the individuals having become taxpayers because of the jobs created by newly established small businesses.

On Balance, the gains made by veterans recently are too significant to be allowed to be reversed. In Fiscal Year 1984 alone, 26.5 percent of all SBA lending dollars (including either direct loans or loan guarantees) went to veterans. Between 13,000 and 15,000 veterans attended SBA seminars and workshops around the country. Another 8,360 veterans received general business counseling and some 93,893 veterans received in-depth business operations instructions.

FEDERAL BUDGETARY TRENDS

After having outlined our objections to those cuts in veterans programs contained in the proposed budget for Fiscal Year 1986, we feel it is incumbent upon us to offer an additional perspective from which to assess the fiscal merits of veterans programs and thereby justify the size of the budget for veterans needed.

As stated early on in this statement, VA has consumed a shrinking share of total Federal spending. The reasons for this are probably several, but there is one very important reason that must be understood clearly. Unlike most entitlement programs, VA programs generally, and readjustment programs specifically, are not open-ended. Instead, they have built-in efficiencies which guarantee precipitous declines in costs. The G.I. Bill education program is a classic example. In FY 1975, the cost of VA education was $4.6 billion. In FY 1984, the cost of VA education was only $1.4 billion. By contrast, the Federal contribution to programs operated by the Department of Education such as Pell Grants, National Defense Student Loans and others over the same period has increased enormously. In our judgment, this is but one example of why it is unwise to hold out the VA budget for cuts on the dubious assumption that fairness somehow dictates that VA must contribute even more than it already has to overall efforts to reduce the Federal deficit. The fact is that VA's budget has always been lean and as such has already been contributing to fiscal cost containment for years.

In another example comparing the growth of entitlements, the cost of the Comprehensive Employment and Training Act (CETA) in Fiscal Year 1975 was $4.1 billion. Under the Job Training Partnership Act (JTPA), the Fiscal Year 1984 cost was $5.1 billion. Even though CETA was replaced with the much more fiscally prudent JTPA, the Federal cost of employment and training increased significantly. By contrast, employment and training programs for veterans have always been limited in both scope and cost and have been carefully tailored to narrowly drawn targeted groups of veterans.

In medical care, VA spending between Fiscal Years 1975 and 1984 rose from $3.7 billion to $8.8 billion. Though this constitutes an increase of 138 percent, the cost of Medicare spending during the same period rose from $12.9 billion to $62.0 billion;

an increase of 380 percent. In the private sector, medical spending between Fiscal Years 1975 and 1984 rose from $66.6 billion to $215 billion, or 323 percent.

With this in mind, the cumulative increase in the Consumer Price Index (CPI) from 1975 through 1984 has been 111 percent. Overall VA spending over the same period has risen only 55 percent; less than half the cumulative CPI. Even in VA expenditures for compensation and pension the increase is well below the cumulative CPI. Between 1975 and 1984 compensation and pension spending rose from $7.9 billion to $14.6 billion, only 85 percent. Given the clear restraint in VA spending over the last 10 years by contrast with the cost of spending on other programs, the VA budget has been a model of prudence; one not needing further restraint beyond what has already been built in.

CONCLUSION

Mr. Chairman and Members of the Committee, in this statement we have addressed a variety of subjects we consider to be of special importance to the nation's veterans that are included in the Budget Message of the Administration for the VA. We have spoken to those programs we believe to be of highest priority in an agency whose activities all are of high priority, because they are intended to respond to the needs, first of those who were disabled in war service, and then to the reasonable needs of all those who served honorably when called to do so by the nation.

Americans are a responsible people, and The American Legion is a responsible organization. We have not, and will not seek from the Government, more than we believe are the just dues of the men and women who have answered the call of the elected government, to defend the national interest in the Armed Forces. As has been stated to the Committee on other occasions, it is the position of The American Legion that when the national priorities are set, funding for veterans programs should rightfully rank second only to national defense, which must be the first national priority at all times.

We endeavor to leave the Committee with the understanding that The American Legion does not feel that the Administration's request for funding of all programs administered by the Veterans Administration is satisfactory. We have offered specific comment on those areas in which we feel funding is inadequate, and we have addressed each of the legislative initiatives with respect to the concerns of this organization. We trust the Committee will examine and consider the problem areas we have identified. As time and opportunity permit, we will be prepared and look forward to the opportunity for discussion and dialogue with the Committee about the various veterans programs the Committee will be considering during the present session.

Mr. Chairman, we appreciate this opportunity to present our views.

Chairman MURKOWSKI. The VFW is next. Mr. Don Schwab.

Mr. SCHWAB. Thank you, Mr. Chairman.

Chairman MURKOWSKI. I welcome you to the committee, and look forward to your testimony.

Mr. SCHWAB. Thank you. The gentleman on my right and your left is Mr. Federico Juarbe, who is our director of National Veterans' Service.

And as the others, Mr. Chairman, I would like to congratulate you on your election to the chairmanship and welcome you. We always do not agree, but we will never be disagreeable.

Chairman MURKOWSKI. I look forward to that.

Mr. SCHWAB. Now I am not an impoverished World War II veteran, and I do not ever expect to be. But the VFW opposes the proposed means test for veterans aged 65 and older, the exclusion from which was established by Public Law 91-500. To repeal this law in our opinion as the administration intends and restrict most non-service-connected care to veterans on the rapidly diminishing pension roll, and those veterans who are medically indigent does not augur well at all for either veterans or the future of the Veterans' Administration's medical care system.

The retrenchment of Medicare benefits and the proportionate increase in necessary Medicare supplemental insurance would work a severe hardship on many veterans, and subject others to the vagaries of the floundering Medicaid system.

According to the House Select Committee on Aging, the impact of a means test on veterans would be considerable. The added cost to Medicare would be as high as $600 million annually. And in researching for this testimony, I got an education about Medicare. I thought that it was $15.60 a month. That is for medical care. But for hospital care, it is $155 a month. Supplemental insurance to cover what is not covered by parts A and B of Medicare runs about $73 a quarter.

Veterans who are now past age 65 who have not previously had Medicare are penalized permanently 10 percent of the cost of parts A and B for each year that they did not apply when they could have applied. So we are talking about getting up around $3,000 for a veteran to be covered with Medicare parts A and B and necessary supplemental insurance.

And on top of that, we are dealing with a diminishing population of veterans that the VA would service. The pension roll is falling rapidly and 2.2 million veterans with service-connected disabilities are going to be dying as well as pensioners. Barring another major conflict, we are going to have perhaps 1.5 million eligible veterans for treatment in VA facilities. You cannot maintain 172 hospitals and all of the other facilities for such a small number of veterans.

That leads to the cutting of personnel, the cutting of money, the cutting of facilities. We have established then a framework that disenfranchises the non-service-connected entirely, and gives those with service-connected disabilities a credit card to go to your community hospital.

We oppose as we did previously the consolidation of 59 VA regional offices into three benefit processing and support activities. The claimant's access to a full and fair hearing would be restricted, since many would be unable to appear before a board out of State.

All of this represents a serious infringement on the veteran's right to due process which is already violated by the denial to veterans of the right enjoyed by other citizens, that of judicial review.

We oppose the increase in the VA home loan guarantee user's fee from 1 to 5 percent. Mr. Chairman, we also oppose the third-party reimbursement. Without delving into the depths of the impediments of this proposal, the VA would need, based upon its own estimate, as many as 2,495 additional FTEE's to handle this extra administrative burden which obviously the administration has no intention of providing, in addition to the expanded ADP capability which would be required.

This situation is further compounded by the additional personnel required to implement the proposed medical care means test and its corresponding workload.

I mention here the proposal in the tax measure to tax VA compensation. I see no possibility of that garnering any support in Congress. But I want to thank those members of the committee who have written to the President and the Secretary of the Treasury in this regard.

Mr. Chairman, the reductions proposed in medical care facilities and construction fly in the face of the VA report on the care of the older veteran. This problem is not going to go away. We taxpayers are going to pay for the care of older veterans. It is merely a question of whether it is to be accomplished with dignity for the veteran and in a cost-effective manner within the VA system, or be bereft of all dignity through reliance on the almost bankrupt and tenuous Medicaid system.

That concludes my summary, and I would be happy to respond to any questions.

Chairman MURKOWSKI. Thank you very much, Mr. Schwab.

[The prepared statement of Donald H. Schwab, director, National Legislative Service, Veterans of Foreign Wars of the United States, follows:]

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

PREPARED STATEMENT OF DONALD H. SCHWAB, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

Thank you for the privilege of appearing before this distinguished Committee to present the views of the Veterans of Foreign Wars of the United States.

My name is Donald H. Schwab and it is my privilege to serve the more than 2 million men and women of the Veterans of Foreign Wars as their National Legislative Director.

The budget proposed by the President for the Veterans Administration for the fiscal year 1986, which commences October 1, 1985, is $26.7 billion in outlays. This figure represents a decrease of $82 million from the current fiscal year and is 2.7 percent of the Federal budget of $973.7 billion in outlays--the lowest percentage of the Federal budget in recent history.

Ostensibly, Mr. Chairman, this proposed budget represents the Veterans Administration's further contribution to the continuing and elusive deficit reduction efforts of the Administration. In reality, however, we of the VFW view

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it as an unprecedented assault on the Veterans Administration and its hospital and medical care system sugarcoated by a proposed 4.1 percent cost-of-living increase in compensation and pension to be effective December 1, 1985.

We of the VFW support fiscal responsibility. We also support fairness and spending priorities which do not skew intelligent, time honored national priorities. Through the budget reconciliation process, the Veterans Administration and veterans have made a very substantial contribution to deficit reduction. How large a contribution is reflected in the following extract of an article written for our February VFW MAGAZINE by the Honorable G. V. "Sonny" Montgomery:

> "It would be difficult to find anyone who doesn't agree that the Nation's soon-to-be trillion-dollar deficit must be slashed. The Committee on Veterans' Affairs, the Congress, and our veterans and their families recognize and agree that the VA must share in this responsibility, and we will continue to do so. The record shows that the VA has accepted cuts, especially over the last four years.
>
> "In Fiscal Year 1981, the Committee was instructed to reduce budget outlays by $400 million; as a result of, among other things, reduced and delayed COLAs and limitations on the presumption of ability to defray medical expenses, we saved $493 million.
>
> "In FY '82, total reconciliation savings reached $446 million; in FY '83, $602 million; in FY '84, $840 million; and in FY '85, reconciliation savings in budget outlays will amount to $1.69 billion."

Mr. Chairman, the VFW has historically held that any honorably discharged veteran who served on active duty in our Armed Forces during periods of war and hostility and in need of medical care should be provided that care by the Veterans Administration. Most unfortunately, and according to its own survey, the Veterans Administration is presently denying that medical care to over 21,000 veterans each month. Now, this Administration has indicated in this proposed budget that it will callously propose legislation to deny medical care to most veterans suffering from nonservice connected disabilities who are not in receipt of pension or medically indigent by subjecting them to a stringent means test regardless of their age. This is contrary to current law and opposed in the strongest possible terms by the VFW.

The primary function of the Veterans Administration's hospital and medical care system is, of course, to provide care second to none for veterans with service connected disabilities. However, the longstanding intent of Congress to also care for veterans with nonservice connected disabilities was clearly enunciated in paragraph 10, Title II of Public Law 68-242, the "World War Veterans' Act, 1924", which is herein quoted:

> "That all hospital facilities under the control and jurisdiction of the bureau shall be available for every honorably discharged veteran of the Spanish-American War, the Philippine Insurrection, the Boxer Rebellion, or the World War suffering from neuropsychiatric or tubercular ailments and diseases paralysis agitans, encephalitis lethargica or amoebic dysentery, or the loss of sight of both eyes regardless whether such ailments or diseases are due to military service or otherwise, including traveling expenses as granted to those receiving compensation and hospitalization under this Act. The director is further authorized, so far as he shall find that existing Government facilities permit, to furnish hospitalization and necessary traveling expenses to veterans of any war, military occupation, or military expedition since 1897, not dishonorably discharged without regard to the nature or origin of their disabilities: Provided, that preference to admission to any Government hospital for hospitalization under the provisions of this subdivision shall be given to those veterans who are financially unable to pay for hospitalization and their necessary traveling expenses."

More recently, Mr. Chairman, Public Law 91-500 made a noteworthy change in that it amended 38 USC 610 by extending eligibility for hospital, nursing home and domiciliary care to "any veteran for a nonservice connected disability if such veteran is sixty-five years of age or older." To repeal this law, as this Administration intends, and restrict most nonservice connected care to veterans on the rapidly diminishing pension roll and those veterans who are medically indigent does not augur well at all for either veterans or the future of the Veterans

Administration's hospital and medical care system. The retrenchment of medicare benefits and proportionate increases in necessary medicare supplemental insurance would work a severe financial hardship on many veterans and subject others to the vagaries of the floundering medicaid system. According to the House Select Committee on Aging: "The impact of a means test on the veteran would be considerable. The added cost to medicare could be as high as $600 million annually." Curtailing the treatment of veterans will create untoward problems for the entire health care system. Such a mandated continuing reduction in patient load would necessitate reductions in health care personnel, hospital and nursing home care beds and, in the not too distant future, a reduction in facilities and the ability of the Veterans Administration to be a viable primary backup to the Department of Defense. The framework would then be in place to disenfranchise all nonservice connected veterans and contract out care for veterans with service connected disabilities.

Mr. Chairman, the Administration has proposed consolidating into three "benefit processing and support activities" the adjudication of veteran's claims and the maintenance of claim files. The remainder of the 59 VA Regional Offices would become mere contact points where a veteran could do little more than file a claim since no records would be maintained at these points and adjudication of claims would no longer be accomplished at the state level. President Reagan's fiscal year 1982 budget contained much the same proposal. The VFW opposed it then and we oppose it now. Reducing VA Regional Offices to satellite or contact points would greatly hinder the ability of our service officers and other representatives to research and present claims at that level since the claim file would not be available to permit the proper and necessary research. The claimant's access to a full and fair hearing would be restricted since many who would be able to appear before a board in his or her own state might well be unable to travel perhaps half the distance of our country to make a personal appearance. Such hearings as might be held locally would, most likely, be before proxies. All of this represents a serious infringement on the veteran's right to due process, which is already violated by the denial to veterans of the right enjoyed by all other citizens--the right of judicial review. The proposed consolidation would, without question, greatly impede the adjudication of claims and the initial payment of benefits to which the claimant is entitled.

The Veterans Administration's loan guaranty program is the most used veteran's benefit under which nearly 12 million veterans have purchased homes. Public Law 97-253 established a user's fee of one-half of one percent on VA home loans effective October 1, 1982, and terminating September 30 of this year. Veterans with service connected disabilities were exempted and the user's fee when collected went to the Treasury, not the loan guaranty revolving fund. Public Law 98-369 increased the user's fee to one percent until September 30, 1987. Funds presently collected are deposited into the loan guaranty revolving fund. Now the Administration proposes legislation to increase the user's fee from one percent to five percent. In addition, it would obligate purchasers of VA owned property who buy on terms (vendee loans) to either pay a five percent fee, or pay a one percent fee, make a minimal five percent downpayment and obtain private mortgage insurance. The five percent user's fee could effectively negate the value of a VA loan for veterans, particularly Vietnam veterans.

Mr. Chairman, proposed outlays for medical care at $9.05 billion represents an increase of 3.4 percent over this year and, according to the Veterans Administration, offsets the inflation in health care. It is anticipated the requested funding will support the treatment of 1.2 million inpatient and 18.7 million outpatient visits. Medical and prosthetic research is down $36.3 million in outlays and Medical Administration and Miscellaneous Operating Expenses down

$10.2 million. Four million two hundred thousand dollars of the latter is taken from the Health Professional Scholarship Program which will be phased out.

Mr. Chairman, average or full-time equivalent employment (FTEE) within the Veterans Administration's Department of Medicine and Surgery is reflected as 192,048 personnel, an increase of 199 over 1985. However, this increase does not in any way enhance care within the existing system since 2,068 FTEEs are allocated to staff new facilities yet to be activated. In reality, the Administration's productivity improvement program will cut 1,916 personnel and an additional 889 personnel will be lost to existing medical, surgical and psychiatric bed sections. Obviously, more emphasis is being placed on extended care facilities. However, the VA is still not operating the 90,000 hospital and nursing home beds mandated by 38 USC 5010, but 89,100.

Mr. Chairman, a reduced construction budget will permit replacement and modernization of hospitals at Houston, Texas and Mountain Home, Tennessee; a clinical addition and nursing home-care unit at Philadelphia, Pennsylvania, plus nursing home-care units at Amarillo, Texas and Tucson, Arizona; and domiciliaries at Temple, Texas and Wood, Wisconsin. Construction will be delayed for hospitals at Augusta, Georgia; New York, New York; and Philadelphia, Pennsylvania, with the attendant increased cost and possible rescission.

Third-party reimbursement, last proposed in President Carter's fiscal year 1981 budget request to save $315 million per year, has again surfaced in the President's proposed budget but with more modest anticipated savings of $65 million per year. According to the Veterans Administration: "...among veterans hospitalized in VA medical facilities, only 55 percent have some health insurance (including medicare and medicaid), while 45 percent do not." Furthermore, it is suspected veterans with private or public insurance seek VA care only when benefits have expired under their policies. Without delving in-depth into the impediments of this proposal, suffice it to say as far back as 1975, the health-insurance industry indicated paying to the VA the cost of care for a veteran suffering from nonservice connected disabilities would increase premiums by at least ten percent for all policyholders. Most health insurance policies contain an exclusionary clause courts have ruled constitutional and the VA would need to develop and maintain a very elaborate cost-accounting system. Moreover, the VA would need, based upon its own estimate, as many as 2,495 additional FTEEs to handle this extra administrative burden, which obviously the Administration has no intention of providing, in addition to the expanded ADP capability which would be required. This situation is further compounded by the additional personnel required to implement the proposed medical care means test and its corresponding workload.

Mr. Chairman, a most important measure not contained in the President's proposed budget but, rather, in the tax-reform legislation proposed by the Department of the Treasury is the unthinkable, insensitive and ill-advised proposal to tax compensation payable by the Veterans Administration to veterans suffering from service connected disabilities. I cannot foresee this proposal garnering any support in Congress, but permit me on behalf of all disabled veterans to thank those committee members who wrote to the President and the Secretary of the Treasury in this regard. In writing to the President, the Commander-in-Chief of the VFW, Billy Ray Cameron, labeled the proposal "inconceivable."

Mr. Chairman, the reductions proposed in medical care, research, grants for construction of state extended care facilities and major construction flies in the face of the Veterans Administration's report entitled "Caring for the Older Veteran." The challenge is not going to go away. We taxpayers are going to pay for the care of our older veterans. It is merely a question of whether it is to be accomplished with dignity for the veteran and in a cost-effective manner within the VA system or bereft of all dignity through reliance on the almost bankrupt and tenuous medicaid system

Mr. Chairman, none of us know at this juncture what budget cuts Congress will agree to in the final analysis. However, we of the VFW believe the Veterans Administration and veterans have made substantial contributions to deficit reduction and that the status quo should now be maintained. If the members of Congress believe otherwise, let them speak and be counted. After all, the President proposes, but Congress disposes.

Mr. Chairman, pertinent resolutions passed by the voting delegates to our most recent National Convention are herein listed and appended to my testimony:

Resolution No. 613--"VA Home Loan Guaranty Program"
Resolution No. 688--"Halt to Reductions of Benefits for Veterans and Military Retirees"
Resolution No. 727--"The VA Budget"
Resolution No. 741--"Third Party Payments for Veterans Health Care"

Thank you and I will be happy to respond to any questions you may have.

Resolution No. 613

VA HOME LOAN GUARANTY PROGRAM

WHEREAS, the VFW views the VA Home Loan Guaranty Program as one of the most successful and beneficial programs available to veterans; and

WHEREAS, this popularity is evidenced by the fact that more than 11 million loans have been approved under this program; and

WHEREAS, we are concerned with the solvency and future of the VA Loan Guaranty Revolving Fund; and

WHEREAS, the rapid depletion of this fund due to the high foreclosure and VA property acquisition rate during recent years may soon require an emergent request for additional funding; and

WHEREAS, a "Grace Commission" recommendation would require the VA to change foreclosure proceedings and permit the lender to take possession of the property to reduce VA property inventory and acquisition costs; and

WHEREAS, it is intimated that such a proposal would be cost-effective, in reality it would be more costly to the VA; and

WHEREAS, such an arrangement would ultimately increase the average VA outlay per house from $9,500 to $19,500 and deplete the revolving loan fund; and

WHEREAS, adoption of the Commission recommendation may result in veterans having to make higher down payments, requiring higher income standards primarily affecting Vietnam veterans purchasing their first home; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we urge the Congress and the Veterans Administration to resist all efforts to implement any portion of the Grace Commission proposal that would jeopardize opportunity for home ownership to any eligible veteran.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 613

Resolution No. 688

HALT TO REDUCTIONS OF BENEFITS FOR VETERANS AND MILITARY RETIREES

WHEREAS, personnel having served in the military services of the United States with honor, did so with the understanding they would have certain future "BENEFITS AND ENTITLEMENTS" for that service; and

WHEREAS, many of these perceived "BENEFITS AND ENTITLEMENTS" were presented in the name of the Government of the United States; and

WHEREAS, these same personnel have steadily witnessed a very real and very steady erosion of these "BENEFITS AND ENTITLEMENTS"; and

WHEREAS, the health services and other services under the preview of the Veterans Administration are either being cut back, eliminated, or are under review by the Grace Commission under the pretense of reducing the national deficit; and

WHEREAS, the current PAY CAPS, REDUCTION IN MEDICAL AND HOSPITAL CARE, AND OTHER PROVISIONS FOR LIMITING PAY RAISES TO DISABLED VETERANS AND RETIRED MILITARY are in effect a very real and burdensome reduction for these personnel; and

WHEREAS, many of these personnel would not have invested substantial portions of their most productive years in the military service if they had not fully believed that these "BENEFITS AND ENTITLEMENTS" would be granted them upon honorable discharge or retirement; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that a resounding call for a total and immediate halt to all measures that threaten the current "BENEFITS AND ENTITLEMENTS" of all veterans and retirees be strongly registered, and that the reductions proposed by the Grace Commission for these deserving people be completely ignored; and

BE IT FURTHER RESOLVED, that the Congress of the United States cause a thorough review of the status of past and current "BENEFITS AND ENTITLEMENTS" of both veterans and retirees for the purpose of stopping any further erosion of those same "BENEFITS AND ENTITLEMENTS"; and

BE IT FURTHER RESOLVED, that the current pay freezes, pay caps, and reduction in cost of living raises be restored to eliminate any further and undue sacrifices by these personnel; and

BE IT FURTHER RESOLVED, that the Congress of the United States guarantee the future "BENEFITS AND ENTITLEMENTS" of the Veterans and Military Retirees, thereby insuring that those personnel making the sacrifices incurred while serving their country do so with full knowledge and understanding of their future "BENEFITS AND ENTITLEMENTS" upon honorable discharge or retirement, and the so called Grace Commission as pertains to reduction of all veteran's benefits be dissolved.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 688

Resolution No. 727

THE VA BUDGET

WHEREAS, there are presently more than 28 million living veterans of whom over 10 million have reached an age where they require increased health care including longterm care; and

WHEREAS, the Veterans Administration's budget has fallen from 5.1 percent of the federal budget in outlays in 1975 to an estimated 2.9 percent in 1985; and

WHEREAS, the Veterans Administration's portion of federals outlay for health care has fallen from 12.5 percent to an estimated 8.6 percent during the same period; and

WHEREAS, according to the House Veterans Affairs Committee, "there is evidence that an artificial 'cap' has been placed on the resources available for outpatient treatment, resulting in a denial of treatment to eligible veterans in some cases, and in other cases resulting in an inappropriate admission as an inpatient," an opinion shared by the Veterans of Foreign Wars; and

WHEREAS, in its report to the budget committee the House Veterans Affairs Committee stated, "...it appears that the facilities which the Veterans Administration presently operates, and which it plans to build or renovate with the funds requested in its 1985 budget, will not accommodate by any measure, the anticipated demand for services over the next 20 years"; and

WHEREAS, the Administrator of Veterans Affairs was quoted in the May 15, 1984 edition of U.S. Medicine as saying that by the year 2000, a 68 percent increase in hospital beds will be needed with special geriatric evaluation units at each medical center, and that outpatient clinics should be able to support 26 million visits with appropriate prevention and geriatric and specialized services and that 30 Geriatric Research, Education and Clinical Centers (GRECCs) should be established by 1990; and

WHEREAS, veterans who served honorably in our Armed Forces during periods of war and hostility have rendered a very special service to our great nation and if in need of health care should be timely provided the finest care by the Veterans Administration, now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we prevail upon the Congress of the United States to pass a budget and appropriation for the Veterans Administration which will fully fund and maintain the integrity of the benefit and entitlement programs and an enhanced Veterans Administration hospital and medical care system.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Resolution No. 727

Resolution No. 741

THIRD PARTY PAYMENTS FOR VETERANS HEALTH CARE

WHEREAS, the Veterans Administration Department of Medicine and Surgery is charged by law and tradition with caring for the Nation's veterans; and

WHEREAS, the veterans of this country are entitled to hospitalization, nursing home care, outpatient treatment and other related health services for the many sacrifices made during service to their country; and

WHEREAS, under the Constitution of the United States of America, the several States are reserved the power to regulate their industries and commerce; and

WHEREAS, the Nation's insurance industry is wholly controlled under laws and regulations administered exclusively by the several States; and

WHEREAS, most health insurance policies contain exclusion clauses which prohibit payment for medical care provided in Federal medical facilities; and

WHEREAS, any Federal legislation granting the United States or any of its agencies the power to collect funds for private insurance companies is unconstitutional; and

WHEREAS, implementation of such a program would require additional appropriated funds and the recruitment of many additional VA staff. This magnitude of resources can be better spent in the direct care and treatment programs of the Department of Medicine and Surgery; now, therefore

BE IT RESOLVED, by the 85th National Convention of the Veterans of Foreign Wars of the United States, that we unalterably oppose any Congressional enactment of legislation empowering the Veterans Administration or any other agency of the United States Government to collect funds from private insurance companies to defray the costs the Nation incurs to care for its veterans excepting beneficiaries covered by Section 629, Title 38, US Code.

Adopted by the 85th National Convention of the Veterans of Foreign Wars of the United States held in Chicago, Illinois, August 17-24, 1984.

Chairman **Murkowski**. On the testimony given by The American Legion, Mr. Sommer, I noted in your legislative initiative that you indicate that The American Legion is opposed to the practical effect of the proposed increase in the loan origination fee from 1 to 5 percent on all guaranteed loans. It would eliminate the advantage of enabling veterans to purchase a home with no downpayment.

What would that have to do with a downpayment?

Mr. **Sommer**. Mr. Chairman, as was mentioned earlier, there are two choices a veteran has to pay this 5-percent user fee, as initiated. No. 1, it is either paid up front, which would be in essence like a downpayment, and probably in many cases more than a normal downpayment would be under a privately secured loan; or, if it was not paid up front, it would be tacked onto the monthly payments for the remainder of the loan.

Chairman **Murkowski**. Well, yes. In reality, the downpayment rate in the commercial mortgage market is 10 to 20 percent, so it's still under the market rate. In reality, when you're offering no downpayment, which the veterans program was originally construed and should continue to be, there is no downpayment. It's just simply a matter of taking those 5 points and amortizing them over 30 years. I think that particular reference needs a little clarification, because it's quite obvious that the program would still be available, if it were passed, with no downpayment.

Mr. **Egan**. Mr. Chairman, we intend to provide this committee with some detailed clarification when you hold your oversight hearing.

Chairman **Murkowski**. Well, I would like clarification of that particular reference to downpayment, because it may cause some unneeded excitement among some of the veterans.

Mr. **Egan**. With regard to downpayments, Mr. Chairman, we should remember that last July, the Office of Management and Budget published Circular A-70, which presumably outlines the administration's desires with regard to Federal credit policies. That circular, if applied to the VA home loan, would require banks to assume some of the risk of the guarantee that they were being provided. And we have to believe that the bankers would pass that risk on to the veteran, and the amount of risk that was being absorbed by the beneficiary of the guarantee would be as high as 20 percent. This means we're talking about applying a 20-percent downpayment to a home loan program, and then if this 5-percent user fee goes into effect, the veteran would be required to pay 5 percent for the privilege.

Chairman **Murkowski**. Well, at that point in time you wouldn't have a program and I do not think that is one of the alternatives because, first of all, the bank makes the loan because of the guarantee. Without the guarantee, the bank isn't going to make a 100-percent loan, and as long as the Federal Government is making the guarantee, what's in it for the bank obviously is the interest rate and whatever other charges they get out of it. But they're not going to make that loan without the guarantee. So I think that's the crucial question.

Mr. **Egan**. Well, we recognize that dynamic of the market, but——

Chairman **Murkowski**. No; that's the uniqueness of the Federal Government's commitment to make the Veterans Home Loan Program go, because it isn't going to go without the guarantee.

Mr. **Egan**. Yet I think we can agree that this administration has some rather pointed views about what role the Federal Government ought to play in Federal credit markets.

Chairman **Murkowski**. Oh, I do not disagree with that at all. But one of the problems, of course, is that everybody has a different responsibility, and one of the responsibilities of those in Government that are associated with this program is to recognize the reality the costs of handling foreclosures—the rate of foreclosures have been extraordinarily high. You're going to have that anytime you have a program where you finance 100 percent of the loan with no downpayment.

But that's fine. That's the way the program was established. But the question that responsible people have to reflect on is, what is the Government's obligation toward the reserve for foreclosure? Since OMB is saying it is not enough, we've had to come in with supplementals, and this is how OMB suggests we go about rectifying it.

When you've got 33,000 foreclosures hanging over your head, you're going to have some tremendous costs.

Mr. **Egan**. Well, we certainly understand that. One of the questions that we've asked in presentations we've made before this committee in the past is whether or not we oughtn't to take a look at how mortgage companies are qualifying veterans before they approve the mortgages. And whether or not——

Chairman **Murkowski**. I think you want to be very careful with that, because if the qualifications get tougher, you're going to serve less veterans.

Mr. **Egan**. Well, we understand that. We understand that. But the veteran who gets into a property that he cannot pay for isn't well served by the guarantee or by the bank.

Chairman **Murkowski**. Well, that's true, but, when you're trying to analyze credibility on a credit basis, you're really relating to the employment picture. I can make a general statement, that if you analyze most of the problems associated with veterans' foreclosures, it has something to do with employment.

Well, I think we're both working on the same level. I would like to see something done about the program. I do not believe that the Veterans' Administration is the most efficient organization to handle 33,000 foreclosures centrally or even regionally, particularly when you've got situations all over the country where a little bank in Pocatello, ID, made a loan to a veteran and that bank foreclosed, and as soon as the process started, the bank got out of it because they were paid in full and then the massive bureaucracy, the Veterans' Administration, has to come in and start the foreclosure process.

By that time 6 months have passed. The pipes are frozen, they get there in the spring, the pipes leak, and it has to be tightened up and redecorated. They've got twice as much of a loss as they would have had if they worked some arrangement locally with the lender to handle the foreclosure and resale.

These are areas that I think need to be examined a little bit to see if we can provide some assistance to make the program more effective. I do not know——

Mr. **Egan**. I agree with you, Mr. Chairman.

Chairman **Murkowski** [continuing]. If 5 points is going to do anything to solve the basic problem.

Mr. **Egan**. We would agree with that. We would agree with that.

Chairman **Murkowski**. Well, maybe we can work together. I'm having a heck of a time trying to get to the bottom of just how the veterans' lending program works in relationship to how the foreclosure starts, how long they keep property and where and why they don't do this or that or the other thing.

But it's coming, and I'd be happy to report back to you.

Mr. **Egan**. Well, we will clarify what was meant by that.

Chairman **Murkowski**. I'd appreciate your comments on this idea of the merits of colocating VA regional offices on the site of VA medical centers.

Mr. **Schwab**. Well, if you mean gearing down and having just a contact point, it would be——

Chairman **Murkowski**. No.

Mr. **Schwab** [continuing]. Highly unsatisfactory.

Chairman **Murkowski**. Moving the whole operation.

Mr. **Schwab**. You mean——

Chairman **Murkowski**. Colocating on the sites of medical centers.

Mr. **Schwab**. The regional offices as they are today with adjudication, with claims files.

Chairman **Murkowski**. That's the question I'm posing to you.

Mr. **Schwab**. I think I will let Mr. Juarbe respond to that one, sir. He has our service office setup.

Chairman **Murkowski**. I'd appreciate having that for the record.

Mr. **Juarbe**. Mr. Chairman, we have not done much study on this issue, but I think the immediate reaction to it would be that there would be some definite advantages to the VA. If you were to colocate all VA regional offices at the hospitals, you go from 59 regional offices to 172 points of contact for veterans to receive assistance with regards to their claims.

In addition to that, there should be considerable savings in the amount of leasing contracts that the VA has to pay to GSA. I think that should provide for better space accommodations which would be much more satisfactory than is now experienced by most regional offices in dealing with GSA.

That's a qualified answer, because we, as I said before, still need to study that situation a lot more.

Chairman **Murkowski**. I would appreciate your submitting for the record any further elaboration you may have on it.

I have no further questions, other than I'm going to stand up and excuse you and shake your hand and welcome the rest of the group.

Come in. I need the exercise.

[The responses of The American Legion and the Veterans of Foreign Wars to written questions submitted by Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs; and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

RESPONSE OF THE AMERICAN LEGION TO WRITTEN QUESTIONS SUBMITTED BY HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. There has been much discussion on the proposed 5 percent fee for the VA's home loan program. The bottom line is that the Loan Guaranty Revolving Fund (LGRF) is bankrupt. An alternative to increasing the funding fee is an annual appropriation approaching one-half billion dollars. This seems unrealistic in light of soaring deficits and competing needs of health-care and other VA programs. What specifically do you believe should be done to rejuvenate this program and to make it self-sustaining once again?

Answer 1.

In this question you assume that the Loan Guaranty Revolving Fund (LGRF) is bankrupt and imply that divided priorities in the VA budget make it imprudent to allocate $500 million in appropriations to maintain LGRF solvency. The American Legion rejects both the assumption and the implication.

Importantly, this is not to deny that the revolving fund is in trouble; it certainly is and along with it the entire home loan program. While the LGRF can be said to be currently dependent on appropriations rather than fully self sufficient, the reasons for this are the alarming increase in the number of foreclosures on VA backed mortgages over the last few years and the short sighted reconciliation requirement that VA sell its portfolio of loans. Importantly, neither of these reasons are the fault of VA nor are they impossible to correct.

There are undoubtedly several causes for the high rate of foreclosures, but one of the most important is the fact that sustained high interest rates on VA mortgages have been difficult for veterans to continue to afford through the first several years of a mortgage's life. This has been especially true of those veterans hardest hit by the nation's most recent deep recession. Given the time it takes to carry out foreclosure proceedings from beginning to end, high foreclosure rates have been sustained over a protracted period of time.

In 1983 a change was made in the home loan program which accelerated the drain on the LGRF, necessitating direct appropriations. The reconciliation act of 1983 required VA to sell its direct loan portfolio. Though short term savings were projected, this move was highly disruptive of LGRF stability. Without the VA loan portfolio, the agency was unable to borrow on its assets to meet guaranty obligations at precisely the same time that foreclosures were increasing dramatically. Between 1983 and 1984 the sales of VA loans netted the Treasury over $1.5 billion. Given the size of this figure, it seems clear that sufficient assets could have been generated to cover shortfalls created by high foreclosure rates without direct appropriations if VA had been permitted to maintain and properly manage its loan portfolio.

Moreover, the solution to the problems of high foreclosure rates and LGRF solvency should be clear. First, interest rates on VA mortgages must somehow be reduced. Given the fact that veterans are finding VA mortgages increasingly difficult to afford, the imposition of a 5 percent user fee can be expected -- as VA spokesmen have already stated -- to reduce program participation by 50 percent. Rather than considering options that will reduce participation, it is critically important that options be considered to increase participation.

In that regard, the Legion has already advanced one suggestion which might give lenders incentives to reduce interest rates for veterans in exchange for increased guaranties. Currently the VA guaranty amounts to the lesser of $27,500 or 60 percent. In an example of how this incentive mechanism might work for first time home buying veterans, lenders could purchase increases in the guaranty in 5 percent increments up to a maximum of 60 percent in exchange for each interest point below the VA established maximum rate. If, for example, the VA rate were 12 percent and if $27,500 constituted 40 percent of a prospective mortgage, the lender could purchase 4 incremental 5 percent increases in the guaranty in exchange for reducing the mortgage interest rate by 4 percent. In this example, a first time home buying veteran could get a 30 year fixed rate mortgage at 8 percent (rather than 12 percent) and the banker could get a flat 60 percent guaranty.

Assuming it can be agreed that high interest rates have and will continue to pose problems for LGRF solvency, the proposal in the fiscal year 1986 budget to revoke the VA Administrator's authority to set maximum interest rates on VA backed loans is also a poor idea. This is because the result will be even higher interest rates for veterans further reducing participation in the program.

With regard to the steps that should be taken to place the revolving fund back on sound financial footing, the VA must first be allowed to rebuild its direct loan portfolio. This should be accomplished by authorizing VA's Direct Loan Revolving Fund (DLRF) to accelerate its lending just as a bank might do given similar circumstances. Were this authority provided, it would offer the commercial lending community an additional incentive to reduce interest rates for veterans in exchange for higher guaranties.

Additionally, funding transfer authority between LGRF and the Direct Loan Revolving Fund must be maintained or strengthened. This will permit each respective fund to back its counterpart.

In conclusion, Mr. Chairman, the problems with the home loan program not only can be solved, but the overall program can be significantly improved. What is needed is lower interest rates for veterans, a reestablished home loan portfolio, greater veteran participation in the program, and the authority for VA to manage its own program. Given these ingredients, the program will be rejuvenated.

Question 2. Please comment on the merits of co-locating VA Regional Offices on the site of VA Medical Centers.

Answer 2. The American Legion would have no objection to co-locating VA Regional Offices on the site of VA Medical Centers, as long as the accessibility of the Regional Offices to veterans, dependents and survivors would not be diminished in any way. We are aware that the Regional Office was co-located with the Medical Center in Sioux Falls, South Dakota and that arrangement has proven to be desirable and accessible. However, there are other areas in which such a move would not be logistically acceptable to us.

Question 3. If the Congress were to support an across-the-board COLA freeze for recipients of all federal benefits, would your organization support this approach for VA compensation and pension?

Answer 3. The American Legion would consider acceding to a COLA freeze for VA compensation and pension only if COLAs were frozen for recipients of all other Federal benefits.

Question 4. Veterans reaching the age of 65 are presumed to be totally and permanently disabled for purposes of eligibility for non-service-connected pension, although veterans reaching the age of 65 are not necessarily totally disabled. I would appreciate having your thoughts on whether it would be advisable to remove the legal presumption which equates age with disability and provide pension only to veterans who actually are totally disabled.

Answer 4. We do not feel it is appropriate to provide an answer to this question without first seeking guidance from The American Legion's National Veterans Affairs and Rehabilitation Commission. This issue will be presented to the Commission during its May 6, 1985 meeting, after which we would propose to communicate with the Committee staff.

Question 5A. Do veterans who use Vet Centers need services other than psychological counseling to aid them in this readjustment?

Answer 5A. Many veterans who seek assistance through the Vet Centers need and receive services other than or, in addition to, readjustment counseling. Vet Center Teams, through networking, currently refer Vietnam veterans to VA or community resources for drug and alcohol counseling and a variety of other services.

Question 5B. If so, do you think my proposal to add drug and alcohol counseling, employment training and placement, and education and rehabilitation services would be useful?

Answer 5B. The readjustment problems of Vietnam veterans is a priority issue of The American Legion, and we are and have been supportive of the development and improvement of a number of programs geared toward special problems that face Vietnam veterans. Examples are improvement and extension of the Vet Center program, special examinations and medical care for veterans exposed to Agent Orange, and badly needed improvements in the diagnosis and treatment of Post-Traumatic Stress Disorder. However, before we would offer comment on the proposal to change the focus of the Vet Center program, it would be necessary that we have the opportunity to review specific, detailed information on the initiative. At this time we do not have sufficient information on which to base responsible comments.

Question 6. Since we have to make hard choices about where to save money this year, could you comment on the relative priority of allocating dollars to staff and hospitals versus beneficiary travel payments?

Answer 6. We view beneficiary travel payments as an entitlement program targeted to the poorest of VA beneficiaries. On that basis we feel that this budget item should be funded. At the same time, it is obviously not possible for the VA medical care system to practice first class medicine without adequate staff, equipment and facilities. The provision of anything less than first class medicine is not acceptable to The American Legion. Therefore, we do not believe it is possible to establish priorities for these budget items.

Questions 7A and 7B. If the Congress adopts third party reimbursements for VA medical care, what is the rationale for excluding from this proposal service-connected veterans who seek treatment for non-service-connected disabilities?

If veterans already have medical insurance, why would using that insurance to pay for their care for non-service-connected disabilities be different than using insurance paid for by non-service-connected veterans?

Answer 7. In our full statement to the Committee several reasons for The American Legion's total opposition to third party reimbursement were set forth. One of the primary reasons is that if third party reimbursement were implemented, the VA health care program would be changed in its essential nature from a benefit to a cost-sharing medical plan, and if that were to happen, we would find it hard to defend the program against vouchering or mainstreaming. The concept included in question 7 follows that rationale. If service-connected veterans were not excluded from third party reimbursement for treatment of nonservice-connected disabilities, it would seem reasonable to presume that the next question would be why exclude service-connected veterans for treatment of diseases or disabilities they incurred while in the military? The next step in carrying this hypothetical situation to its illogical conclusion would be to voucher all veterans into private sector medical care facilities that are unsympathetic to veterans, and that have a primary goal of amassing a profit. The American Legion stands fast in its opposition to third party reimbursement of the costs of medical care to any veteran treated in the VA system.

Question 8A. What are your views on the current prioritization for VA medical care?

Answer 8A. The current list of priorities for admission to care, once past medical emergencies and the treatment of service-connected veterans, has in our judgement become complicated and difficult to apply at the individual VA medical centers. We would agree that it perhaps needs to be reviewed and recodified in a manner more understandable to VA admissions clerks, and the veterans who are seeking treatment.

Question 8B. Do you have any thoughts or suggestions about how, or if, the current system could be improved to provide combat veterans with a priority for medical care services commensurate with their sacrifices?

Answer 8B. In our judgement, if any move is made to establish a priority for care for combat veterans, Congress is going to get into a tangle it will never get out of. For example, was combat more severe in Vietnam than in World War II, or vice versa, and why? Should a soldier who had 100 days of combat have higher priority than one who had 50 days of combat? Or if a priority is established for combat soldiers, what about entitlement to those who had extremely hazardous service but were not face to face with an enemy, such as espionage, reconnaissance patrols behind enemy lines, testing of extremely dangerous new weapons systems, etc., etc. How is Congress going to differentiate, and how will it answer those who are left off the list and think they should be on it? These are merely some of the questions that will arise if Congress chooses to move in this direction.

RESPONSE OF THE AMERICAN LEGION TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. I share The Legion's concerns, expressed on page 14 of your statement, about the possible impact of reductions in research funds on the VA's ability to recruit and retain sufficient high quality physicians. For the record, would you please submit copies of whatever material you are aware of that relates to the physician losses in recent years that you ascribe in your statement to research funding cutbacks?

Answer 1. Much of our information on the loss of VA researchers as a result of insufficient funding of the VA medical research program has resulted from discussions with VA physicians involved in research. For many years there was no growth in the research budget, and as a result, it did not keep up with inflation. Therefore, the program actually lost ground. One example of the adverse effects of inadequate research funding was experienced by VA in FY 1982. As a result of a reduction in the medical research budget, the Career Development Program was forced to reduce the number of particpants, which is normally 200 or more, back to 162. This research program is used to attract qualified clinicians by providing an opportunity to develop a leadership position in VA as a clinician-researcher. Many graduates of this program are employed in responsible supervisory and staff positions in the VA system. VA also attracts highly qualified clinical personnel through investigator-initiated research programs. The proposed FY 1986 budget reflects cuts in the Career Development Program of over $1.1 million and 30 FTEE, and decreases in Investigator-initiated studies of $2 million and 100 FTEE.

Question 2. I appreciated your detailed analysis of the situation with respect to the nursing home care unit in Providence, Rhode Island, and wanted to let you know that I intend to pass along your testimony to the General Accounting Office and ask GAO -- after consulting with both national and local officials of The American Legion -- to respond to your points.

Answer 2. The American Legion welcomes the opportunity to discuss the need for the nursing home care unit in Providence with representatives of the General Accounting Office, and to share with GAO the information that we have compiled relative to such needs.

Question 3. In connection with the A-76, contracting-out process, please indicate whether you support or oppose VA hospitals' contracting out for food services, for fire protection, for plant maintenance, and for housekeeping, and why.

Answer 3. In consideration of OMB Circular A-76, two points must be kept in mind. The provisions of section 3310 of title 5, United States Code, require that positions of guards, messengers, elevator operators and custodians be restricted to veterans, and second, the Government is legally obligated to provide a comprehensive program of medical care to the nation's sick and disabled veterans. We do not believe VA can conduct its medical care program properly if it proceeds to contract out any of the functions of that program, with very few exceptions.

With respect to contracting out of dietetic service in VA medical center, as we understand it, VA dietitians would continue to prepare and supervise menus and nutrition diets prescribed by physicians. The food preparation and delivery would be contracted out. We do not feel that such a proposition is feasible. First, VA dietitians could not assure the quality of food preparation if the food workers were not under their operational control. This could affect the quality of the food prepared and served to patients. Second, what if the contractor experienced a strike? What guarantee could be given for preparation and delivery of food and special diets? It has to be realized that the absence of one meal, or of one special diet could, in the extreme, cost the life of a very sick patient. How would VA ever answer to that eventuality? It certainly would not suffice for OMB to declare they never intended for that to happen. The loss of even one patient in these circumstances would lead to charges that VA could never defend. The food service in a VA medical center must be considered to be the complete and final responsibility of the medical center management and the physicians who are treating the patients.

Similar cases may be made for fire protection, plant maintenance and housekeeping. There is very little going on in a hospital that can be entrusted to anyone except the management and staff of the hospital. The care and welfare of patients must be assured by the complete control and ultimate responsibility of the hospital staff. This leads us to conclude that the possibility of contracting out hospital operations is a very dubious idea, and we are opposed to contracting out for each of the services listed.

Question 4. Please let me have your organization's views on the proposal put forward by the Vietnam Veterans of America to establish a commission -- along the lines of the so-called "Bradley Commission" -- to conduct a comprehensive review of veterans' programs.

Answer 4. We do not see where a review of veterans programs by an appointed or contracted commission would serve any useful purpose. Congressional oversight of VA benefits and medical care provides far greater scrutiny of these programs now, than ever before in the history of the Veterans Administration. In addition, the Administrator has the authority under section 219 of title 38, to review and examine the efficacy and efficiency of all VA programs, and constantly evokes that authority through the Office of Program Planning and Evaluation, and through departmental reviews and audits of the various benefits. In addition, the Office of the Inspector General closely examines all aspects of the agency. We have seen the recommendations of various organizations, unfamiliar with the Veterans Administration, that have studied VA programs such as the 1980 Heritage Foundation report, and the more recent report of the Grace Commission. If implemented, the recommendations set forth by these groups would result in the demise of the Veterans Administration.

Question 5. Please amplify, for the record, the concerns you have regarding the proposed 5-percent loan guaranty origination fee, in light of your discussion with Senator Murkowski on this point at the hearing.

Answer 5. In your fifth question, we are asked to clarify our concerns about the proposal to increase the home loan user fee from 1 percent to 5 percent. In our view, such an increase could be seen as constituting a down payment requirement for veterans using the program if the user fee were paid at the time of settlement instead of amortized over the life of the mortgage. During the dialogue betweeen Chairman Murkowski and me, it was suggested that the user fee increase would not constitute a down payment because even at 5 percent it would still be well below the 10 - 20 percent required on conventional mortgages. Though there may be some merit to this reasoning, the Legion cannot agree to any increase in the user fee regardless of whether or not it is seen as a down payment.

Apart from the unacceptability of a user fee, the home loan program is in clear need of reform. If veterans are to avail themselves of this program in any meaningful sense, particularly among younger first time home buyers, several reforms should be explored fully. Moreover, the Legion put forward its recommendations on this important subject last February when the Veterans Affairs Committee held an oversight hearing. Unfortunately, in the year that has passed since we made our recommendations, there has still been no meaningful dialogue on comprehensive home loan program reform.

In our judgment, the rise in home loan foreclosure rates bears more than a passing relationship to veterans being qualified for home loans they cannot afford. To address this problem, we have suggested providing lenders with incentives to reduce home mortgage interest rates below the rate established by the VA Administrator.

An example of how this incentive mechanism would work may help to clarify the matter. If a first time veteran home buyer were seeking a mortgage on a property, the lender could purchase an increase in the guaranty in 5 percent increments up to a maximum of 60 percent in exchange for each interest point below the VA established rate. If in our example, $27,500 represented 40 percent of the mortgage, the lender could purchase an increase in the VA guaranty in 5 percent increments up to 60 percent by reducing the interest rate by 4 percentage points. If the VA rate were 12 percent at the time of purchase, the rate applied to a 30 year fixed rate mortgage for the veteran could be reduced by as much as 4 percent; each percent representing a 5 percent incremental increase in the guaranty.

Question 6. On page 4 of your testimony, in connection with the third-party reimbursement proposal, you state that you "have heard statements made by VA officials during Congressional hearings to the effect that the administrative costs necessary to implement the mechanism for collection of insurance payments would probably exceed the costs that are recovered." Please identify those statements (by reference to the published hearings wherever possible).

Answer 6. Following the testimony of DM&S officials during a hearing before the Committee, June 9, 1982, on oversight of the Veterans Administration's Outpatient Health Care System, Chairman Simpson asked a series of questions regarding various alternative proposals relating to the provision of VA health care. In response to a question on the idea of third party reimbursement a VA witness stated as follows: "There have been, as you say, Mr. Chairman, several previous requests to study copayment or collection from other Federal agencies. There is one major basic problem for the agency that creates for us an automatic request for increased funds: We lack the manpower at the present time for copayment, for billing of medicare, to assume those just paper processing activities. It would mean essentially an add-on of $22.5 million in payrolls for the various people to do that work, plus the startup costs for an automated information system to process the bills, and all the tangential costs of stationary for billing and postage.

"In addition, we have the problem that our track record on collection, because of the income level of our patients, is such that if we were to say that we would recoup, for example, $150 million, our rates of collection is 31 percent or less. So what you would be assuming would be saved is not going to be saved. And costs would have been expended by the agency.

"We are then faced with other problems that would come about such as if we did have a user fee or copayment, if the patient didn't pay the first time and became ill and came back, are we to refuse that person admission? There become some rather grave medical ethics questions involved with this practice or policy.

"As far as billing medicare and office of workers compensation, we are able to reclaim funds from workers compensation, and this is done with the help of VA district counsels. In only one area are we recouping funds at the present time from medicare, and that is for hemodialysis patients.

"Again, we come to what I believe has been the legislative history when such proposals have been made that while it is a matter of the same Federal dollars, it has been looked at in the past as an erosion of the Department of Medicine and Surgery.

"We can do the billing but it will require that the agency request additional staff."

RESPONSE OF THE VETERANS OF FOREIGN WARS OF THE UNITED STATES TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. I was particularly interested in your views on the health-insurance reimbursement question, an issue that I'm sure the Committee will be addressing this year. Would you please provide copies of whatever material you are aware of that relates to the impact on insurance premiums of the enactment of such legislation?

Answer 1. When J. Maurice Miller, Jr., Senior Vice President of the Life Insurance Company of Virginia, testified before the Subcommittee on Hospitals of the Committee on Veterans' Affairs, United States House of Representative, on Friday, July 11, 1975, he stated in part: "Our estimates, in case there is a question on it, that to cover the cost of this, insurance premiums for male insurance will probably jump about ten percent." Again, when a representative of the Blue Cross and Blue Shield Association testified before the Subcommittee on Military Personnel and Compensation of the House Armed Services Committee on March 29, 1985, the following was stated: "Simply put, we do not charge premiums for benefits we do not provide. Accordingly, if insurers were required to pay for care provided in military facilities, premiums would rise." Extracts of the cited documents are attached.

Question 2. In connection with the A-76, contracting-out process, please indicate whether you support or oppose VA hospitals' contracting out for food services, for fire protection, for plant maintenance, and for housekeeping, and why.

Answer 2. Although not included above, permit me to state for the record, the VFW is adamantly opposed to the contracting out of any hands on medical care and record maintenance. Further, we oppose contracting out food services because of the wide varieties of diets required and the necessity for the strictest sanitation in food preparation and service. Also, we continue to oppose contracting out of jobs specifically reserved for veterans under the provisions of 5 USC 3310 which includes custodial personnel.

Question 3. Please let me have your organization's views on the proposal put forward by the Vietnam Veterans of America to establish a commission--along the lines of the so-called "Bradley Commission"--to conduct a comprehensive review of veterans' programs.

Answer 3. The last thing the veterans of this Nation need is another "Bradley Commission."

(ATTACHMENTS)

OPERATION OF VA MEDICAL PROGRAM

VA Reimbursement for Health Care in Certain Cases

FRIDAY, JULY 11, 1975

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS OF THE
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The subcommittee met, pursuant to notice, at 10:12 a.m., in room 334, Cannon House Office Building, Hon. W. G. (Bill) Hefner presiding.

Mr. HEFNER. The subcommittee will come to order.

This is quite a promotion, from one end of the spectrum to the other, to be presiding.

Mr. Satterfield, our subcommittee chairman, is tied up on the House floor with the health manpower bill today.

This morning the subcommittee will receive testimony on H.R. 4009 which has been proposed by the administration.

Mr. HEFNER. H.R. 4009 proposes to amend title 38 of the United States Code to require that certain veterans receive hospital care from the Veterans' Administration for non-service-connected disabilities to be charged for such care to the extent they have health insurance or similar contracts with respect to such care; to prohibit the future exclusion of such coverage from insurance policies or contracts.

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Mr. HEFNER. Our next witness is Mr. Maurice Miller, Jr., senior vice president, the Life Insurance Co. of Virginia, representing the Health Insurance Association of America.

STATEMENT OF J. MAURICE MILLER, JR., SENIOR VICE PRESIDENT, THE LIFE INSURANCE CO. OF VIRGINIA, ACCOMPANIED BY JAMES BARRETT, EXECUTIVE VICE PRESIDENT, MUTUAL OF OMAHA, AND DAVID P. LAMBERT, COUNSEL, HEALTH INSURANCE ASSOCIATION OF AMERICA

Mr. MILLER. Thank you.

I am accompanied by Mr. James E. Barrett, executive vice president, Mutual of Omaha and David P. Lambert, counsel, Health Insurance Association of America.

I have a statement, Mr. Chairman and gentlemen. I will try to summarize for you.

The statement will go into some detail.

I would like to get to the highlights of it in the interest of your time.

I am here today in behalf of the Health Insurance Association of America. The HIAA is responsible for about 85 percent of all health insurance written by insurance companies in the United States today. Our testimony will address itself to H.R. 4009, legislation which Congressman Satterfield and Congressman Hammerschmidt introduced at the request of the administration.

H.R. 4009 provides that (1) veterans who are covered under private health insurance policies, Blue Cross and Blue Shield contracts or similar arrangements, who choose to go to a VA hospital, will be charged for their care in the VA hospital to the extent of the benefits contained in their private insurance coverage; and (2) no insurance policy or hospital or medical service contract entered into, renewed changed or amended after the effective date of the proposed bill will be permitted to exclude from coverage the charges for hospital care made by the VA hospital if such care would be covered when furnished by other public or private facilities.

It is our opinion that this bill is not in the public interest and therefore should not be enacted. The reasons for this view are summarized as follows:

Private health insurance covered approximately 170 million persons under age 65 in this country at the end of 1973. Of this total, over half were insured with insurance companies. The balance were insured by Blue Cross plans and similar community or medical society sponsored prepayment hospitalization plans.

Both organizations exclude coverage with respect to confinements in VA hospitals. The last witness testified that this was not the case prior to the *St. Paul* case in 1956 and 1957. I have been with my own company since 1953 and I know it was the case with that company prior to the *St. Paul* case.

It was my understanding that it was fairly uniform prior to the *St. Paul* case and that that case really represented the first meaningful litigation of the issue. But in any event, be that as it may, it is not a question, as we see it, of subsidy of insurance companies by the VA. Quite the contrary, this coverage has never been included in contracts. The rates have not been constructed to contemplate this type coverage. So if you really look at it in terms of the way it actually is, to extend coverage by a legislative enactment forces the insuring public, really, to subsidize the VA hospital. The insuring public, of course, includes the veterans and nonveterans alike. So we see the subsidy in exactly the opposite terms. Now in designing hospital insurance protection companies have to follow rather fundamental underwriting principles; namely, that the purpose of the insurance should be to compensate for an actual loss or expense to the person insured. As a result, hospital insurance policies do not generally make provision for payment with respect to hospital stays which cost the patient nothing.

For example, hospital insurance policies, and for that matter Blue Cross prepayment plans as well, do not normally pay for hospital stays resulting from occupational accidents, because such stays are covered by workmen's compensation laws and there is no medical financial loss to the patient.

The question of VA authority to collect for treatment rendered an insured veteran was thoroughly considered in *United States v. St. Paul Mercury Indemnity Company*, 133 Fed. Supp. 726 (D. Neb. 1955). Aff'd 238 Fed. 2d 594 (8th Cir., 1956).

This case involved an insurance contract which provided benefits for "expenses actually incurred" by the insured. The VA sought to make a charge to the veteran confined for a nonservice connected disability, as a basis for collection, from the insurer as assignee of the veteran.

The court found that the only prerequisites to hospital treatment by the VA in the nonservice-connected category, are that there be room available in the hospital for the patient, and that the patient declare under oath his inability to defray the necessary expense of care.

The district court and the circuit court of appeals held that the insurer was not liable for the "costs" of care rendered by the VA hospital since there was no expense incurred by the insured veteran, and thus he had no benefits capable of assignment to the VA.

The matter of increasing hospital costs and resultant increases in insurance premiums has been of growing concern to employers, unions, and the general public. It is a matter of great public ferment today. The enactment of this bill will increase still further the cost of hospital insurance premiums to all, including veterans who carry health insurance themselves or with the aid of contributions from their employers.

The claim costs incurred under the provisions of H.R. 4009 would become an additional charge on the insuring public. Right now that charge in effect is levied through the tax sources on the entire community. The Bureau of the Budget estimates these claims at approximately $122 million in fiscal 1976.

While we have no way of verifying the accuracy of this estimate, we do know that buyers of hospital insurance must, in the long run, pay through premiums what the companies pay in claims.

Moreover, these claim payments, while increasing the costs of insurance, would not provide any additional benefit for the veterans.

What has in the past been a tax supported VA hospitalization program would, under this bill, become only a partially tax supported hospitalization program with the balance of the cost being paid by that part of the public which buys insurance. This, we feel, would discriminate against employers, organized labor, and individual buyers of hospital insurance.

I might point out another public discrimination—medicare. I understand medicare excludes confinement in a VA hospital. The veteran paying for hospital and medical insurance, group or individual, would eventually be required to pay more premium for the increased costs of coverage which he will incur under the proposed legislation.

The veteran who does not carry insurance would be eligible for the same treatment in a VA hospital. Hence, the veteran paying for hospital medical coverage is discriminated against by being required to pay higher premiums for his insurance.

If the oath as to inability to bear the expense is to be continued, which it no doubt would under this bill, and changed only as to the presence of insurance, it would seem that the discrimination noted earlier is compounded.

~~We be~~lieve it would be anomalous to determine an individual able to defray the costs of hospitalization based solely on maintenance of insurance coverage but without regard to the extent of other resources.

Some testimony has been given and questions asked with respect to length of stay in veterans hospitals. That has considerable bearing on the cost involved to be undertaken to be covered by this bill.

Insurance must move within definite bounds, technically known as the limits of actuarial probability.

Premium rates are determined and based upon these probabilities. It is therefore essential to the computation of premium rates that an average length of stay in a hospital be known.

On the basis of our information, the length of stay in a VA hospital is longer than in private hospitals for the same types of conditions or treatment.

This disparity is due mainly to the differences in the types of care given VA hospitals, unlike private hospitals, generally have patients hospitalized during diagnosis and during convalescent care, but there are other factors, such as absence of cost to the patients and probably some tendency in hospitals with light patient loads to continue care beyond necessary limits, which no doubt contribute to the extended length of stay.

As far as the insurance aspects, whether by Blue Cross or commercial carriers, in this particular context coverages in recent years have and comprehensive, which provide both outpatient and custodial coverage as well as inpatient care.

Commercial and community hospitals have a rather strong incentive and the patient himself has a strong incentive to remain confined no more than necessary. I think the prior witness mentioned the fact that diagnostic workup is quite frequently done in an outpatient capacity. Convalescent treatment may also be done on an outpatient capacity. That is considerably less expensive than confinement. That makes a material difference in the cost whether this program is going to be extended or not.

It is because of this disparity that confinement in governmental hospitals sometimes becomes an uninsurable incident, at least under a policy carrying a premium rate for individuals based on confinement in nongovernmental hospitals. Insurance company rates and premiums are actuarially computed on the basis of the shorter non-Government hospital stay. If they were not, a much large premium would need to be charged to reflect the longer expected stay in VA hospitals. Therefore, policies designed to pay for the average stay in civilian hospitals have lower premium rates. The result of the proposed authority for VA to make a charge based on insurance is that all policyholders would pay higher premiums. The policyholders—not the companies—would pay these greater costs.

H.R. 4009 RAISES SERIOUS QUESTIONS OF REGULATION AND CONSTITUTIONAL VALIDITY

It also raises a question with respect to congressional policy. For the first time it would dictate the terms and provisions which may be contained in insurance policies. This is regulation by the Federal Government in the strictest sense and would be inconsistent with the principle of the McCarran Act enacted by Congress in 1917 which has since then been fairly consistently followed. It gives to the States the right to regulate the business of insurance and prescribes the nature of coverage provided by contracts.

The Comptroller General of the United States has pointed out—Report to the Subcommittee on Executive Reorganization, Committee on Government Operations, U.S. Senate, February 13, 1970, page 13—that there may be a question of constitutionality of Federal legislation in this area which would interfere with the rights of parties to contract. H.R. 4009 most certainly would interfere with the right to contract with respect to the payment or nonpayment of VA hospital charges.

In addition, it is submitted that a serious constitutional question is raised by application of the provisions in H.R. 4009 to contracts already in force, renewed or in any way amended after the bill's effective date because the bill undertakes to apply to contracts which are, in effect, amended or renewed after the effective date.

Health insurance policies sometimes remain in force for many years and under guaranteed renewable and noncancellable policies, which are in the majority today, may be renewed from term to term solely at the option of the insured. The insurance company has no control over such renewals [illegible] coverage would be required whenever there was an amendment to the contract, no matter how minute. The net effect would be to apply the requirements of the bill to a great number of contracts entered into prior to introduction or enactment of the new provisions. Thus there would be a serious impairment of existing contracts.

In the group field, it is well known that many group insurance contracts are issued under the specifications laid down by collective bargaining agreements. As noted above, most of these contracts, if not all, contain a VA hospital exclusion. While these contracts are technically issued for a term equal to the term of the collective bargaining contract, many are "renewed" annually or at some other period for the purpose of experience rating and other reasons. Again, the application of H.R. 4009 would result in a serious impairment of contracts already in force.

It is submitted that the bill raises serious questions of due process as enunciated in the fifth amendment to the U.S. Constitution.

CONCLUSION

For the reasons stated above we would urge you to reject H.R. 4009 or any similar legislation. It would unfairly discriminate against the insuring public, veteran and nonveteran; unfairly and unnecessarily increase the costs of health insurance for all insureds at a time when employers, unions, and the public generally are voicing serious concerns over rising costs for such insurance; and it would raise serious constitutional questions.

In general, I think it again raises an issue that perhaps should not be raised at this time or in this context insofar as the role to be played by Veterans' Administration hospitals in our national health care delivery systems, because it does tinker with the system in a rather material way.

Our estimates, in case there is a question on it, that to cover the cost of this, insurance premiums for male insurance will probably jump about 10 percent. Of course if and as the VA hospital system is reexamined and brought perhaps more in conformity with private and commercial hospitals, those rates might change. To the extent they do not and there is a rise in hospital care, there might be a further disparity.

Mr. Chairman, that concludes my remarks, unless there are questions.

Mr. Hefner. Thank you, Mr. Miller.

Since you did not follow your text verbatim, we would like it to be entered into the record in full.

Mr. Miller. Yes, sir.

[The statement follows:]

Statement of J. Maurice Miller, Jr., of the Health Insurance Association of America

My name is J. Maurice Miller, Jr. and I am Senior Vice President of the Richmond Corporation, Richmond, Virginia. I am here today in behalf of the Health Insurance Association of America. The HIAA is responsible for about 85% of all health insurance written by insurance companies in the United States today. Our testimony will address itself to H.R. 4009, legislation which you and [illegible] insurance policies, Blue Cross and Blue Shield contracts or "similar arrangements", who choose to go to a Veterans' Administration hospital, will be charged for their care in the VA hospital to the extent of the benefits contained in their private insurance coverage; and (2) no insurance policy or hospital or medical service contract entered into, renewed, changed or amended after the effective date of the proposed bill will be permitted to exclude from coverage the charges for hospital care made by the VA hospital if such care would be covered when furnished by other public or private facilities.

It is our opinion that this bill is not in the public interest and therefore should not be enacted. The reasons for this view are summarized as follows.

THE PRESENT PRACTICE OF INSURERS

Private health insurance covered approximately 170 million persons under age 65 in this country at the end of 1973. Of this total, over half were insured with insurance companies. The balance were insured by Blue Cross plans and similar community or medical society sponsored prepayment hospitalization plans.

The basic mechanisms used by insurance companies to provide hospitalization insurance protection include group insurance policies covering a number of persons under one single master policy, and individual policies covering individuals or members of a single family. Group insurance policies frequently are purchased in connection with employee welfare plans, in which instance the employer pays all or a substantial part of the cost of the coverage. Individual policies, on the other hand, usually are paid for wholly by the persons insured.

In designing hospitalization insurance protection, insurance companies have followed a fundamental underwriting principle which holds for all similar lines of insurance, namely, that the purpose of the insurance should be to compensate for an actual loss or expense to the person insured. As a result, hospital insurance policies do not generally make provision for payment with respect to hospital stays which cost the patient nothing. For example, hospital insurance policies, and for that matter Blue Cross prepayment plans as well, do not normally pay for hospital stays resulting from occupational accidents, because such stays are covered by workmen's compensation laws and there is no net financial loss to the patient.

THE PRESENT LAW

The question of VA authority to collect for treatment rendered an insured veteran was thoroughly considered in *United States v. St. Paul Mercury Indemnity Co.*, 133 Fed. Supp. 726 (D. Neb. 1955). Aff'd 238 Fed. 2d 594 (8th Cir., 1956).

This case involved an insurance contract which provided benefits for "expenses actually incurred" by the insured. The VA sought to make a charge to the veteran confined for a non-service connected disability, as a basis for collection, from the insurer as assignee of the veteran. The court found that the only prerequisites to hospital treatment by the VA, in the non-service connected category, are that there be room available in the hospital for the patient, and that the patient declare under oath his inability to defray the necessary expense of care.

The District Court and the Circuit Court of Appeals held that the insurer was not liable for the "costs" of care rendered by the VA hospital since there was no expense incurred by the insured veteran, and since he had no benefits capable of a assignment to the VA.

H.R. 4009 WOULD INCREASE THE COST OF PRIVATE HEALTH INSURANCE FOR ALL, INCLUDING VETERANS

The matter of increasing hospital costs and resultant increases in insurance premiums has been of growing concern to employers, unions, and the general public. The enactment of this bill will increase still further the cost of hospital insurance premiums to all, including veterans who carry health insurance themselves or with the aid of contributions from their employers.

The claim costs incurred under the provisions of H.R. 4009 would become an additional charge on the insuring public. The Bureau of the Budget estimates these claims at approximately $122 million in fiscal year 1976. While we have

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STATEMENT
OF THE
BLUE CROSS AND BLUE SHIELD ASSOCIATION

ON

DEPARTMENT OF DEFENSE
MEDICAL FACILITIES REQUIRING PAYMENT
FROM PRIVATE INSURANCE

FOR THE

HOUSE ARMED SERVICES COMMITTEE
MILITARY PERSONNEL AND COMPENSATION SUBCOMMITTEE

MARCH 29, 1985

The Blue Cross and Blue Shield Association is pleased to present this statement for the record concerning the Department of Defense's (DoD) Fiscal Year 1986 budget proposal to require available private insurance to pay for care provided in military facilities to nonactive duty personnel, including dependents, survivors, and retirees and their dependents. Our Association is the coordinating organization for the nation's Blue Cross and Blue Shield Plans. Through these Plans, private and public health insurance benefits are provided to some 100 million people.

We strongly oppose DoD's proposal for the following reasons:

1) It violates the principle of insurance;
2) It violates the protection of the Fifth Amendment of the Constitution; and
3) It shifts to the private sector — primarily employers — a new set of financial obligations without the safeguards needed to contain health care cost increases.

Before addressing our concerns in more detail, it is important to review briefly how insurance premiums are established, and what effect this new policy would have on them. We want to correct any misconception that insurance companies have been reaping "windfall profits" by not reimbursing for care provided in military hospitals; that allegation is simply not true. The premiums or costs of an insured group of individuals are based on actual payment for services that are covered and used by the group. Insurance contracts specifically exclude payment for services for which there is no charge, such as those provided in government-owned facilities like military hospitals. Because payment cannot be made for these free services, their cost is not reflected in the group's premium. Simply put, we do not charge premiums for benefits we do not provide. Accordingly, if insurers were required to pay for care provided in military facilities, premiums would rise.

Chairman MURKOWSKI. Mr. Chad Colley. Thank you for your patience, sir. I welcome you as national commander of the Disabled American Veterans, and I apologize for having kept you waiting so long.

Please proceed.

TESTIMONY OF CHAD COLLEY, NATIONAL COMMANDER, DISABLED AMERICAN VETERANS

Mr. COLLEY. Thank you, Senator. I'd like on behalf of my organization to offer our congratulations to you on your elevation to the chairmanship.

Chairman MURKOWSKI. Thank you.

Mr. COLLEY. And we also appreciate the enthusiasm that you bring to this job, which was ably chaired by two other gentlemen who form a base of knowledge that I think is going to serve the veteran community very well.

I appreciate the opportunity to submit for the record our written remarks, and I will have a brief summary. The question may cross your mind, just exactly why the national commander has chosen to appear before this committee today when you're going to hear from me in less than a week, and we have very able and capable staff members able to articulate the needs of our organization.

I think in no small part is the fact that I personally and my organization believes that the preparation of and adoption of the 1986 fiscal year budget is going to be a pivotal time as it relates to veterans and veterans' programs.

We believe that this is so because in years past the straight line budgeting has been accommodated simply from the fact that we've not had a great burden placed upon the system yet.

We think the aging veteran population may well change this in the future. It's also a time when and if this budget is adopted as it is offered, we think it will point to the day of the demise of the Veterans' Administration's ability to care adequately for the men and women who have served our country in a very special way.

We're also concerned that some of the proposals are wholly unrealistic in their outlook. We're also concerned about some of the nonbudgetary actions which also leave some question in our minds.

If there's anything that I as an individual disabled veteran fear, it's that we're seeing some sweeping change to the programs of the Veterans' Administration which are not mandated by the Congress or this committee, but are being done in a very insidious way, sometimes very difficult to diagnose until they're well into the meat of the program or into the benefits that are so necessary to disabled veterans.

At first blush the Medical Care Program seemed adequate. It's a 2.6-percent increase, and this equates to well over $2 million, which seems like an awful lot of money to an individual from Fort Smith, AK. But when you look at the fact that this provides services that are 3.5 percent below what the same care would be provided for in the civilian medical community, there's a little flag that goes up in my mind saying "How does this really equate to the needs of our veterans?"

When I look at the fact that for some reason we've chosen to have 600 fewer beds in our acute medical care and nursing care than was allocated and mandated by law by the Congress, this sends up a little red flag saying "How can we equate that, with the quarter of a million veterans that have been turned away from the medical care system?"

If 600 beds is not a deciding factor, what happens when it becomes 900 beds? How many beds are going to be less than those allocated by the Congress before we really get concerned about it?

I was so pleased to hear the opening remarks of some of the members of this committee, because they share some of the concerns that we have as members of the Disabled American Veterans.

Now, I'm concerned with the fact that somehow we're able to do with 2,000 less people in medical service than was mandated by the Congress, and somehow the Comptroller General has certified that OMB has provided funds for that many people.

Yet we see that they're not on the rolls. Factors such as 1 percent across-the-board staffing reductions and 5 percent reduction in pay for Federal employees. We know directly it's going to have some effect on the quality of care that's provided for the Nation's veterans.

We look at third-party reimbursements, and can see that this is possibly fraught with problems. We think that the projections are overly optimistic, and our questions to exactly how these figures are arrived at are not always adequately—for our own information adequately addressed.

OMB, for example, started 3 years—4 years ago saying $300 million could be saved, and now that figure is down to $65 million. We think that this really could provide a shell game when you start involving the means test criteria.

We're convinced that if you take a certain segment of the VA population that is currently receiving treatment and somehow deny it—we're firmly convinced that those same beds are going to be occupied by worthy and needy veterans.

We look at the fact that Public Law 96-330 gave the authorization to develop a means test, but only now is that seemingly getting serious consideration. And it was acknowledgment that this means test was going to replace or take in the desirable features of a third-party reimbursement.

We just don't feel that you can have it both ways in that regard. We also are distressed, as was some of the members of this committee, that construction funds are being reduced. You know, when I went to the VA Medical Center 3½ months after I was injured in Vietnam, the most available bed that I had in that hospital was in a geriatric ward.

I was the only one of eight men in that ward that wasn't fed through the nose and diapered. But that gave me a real and vivid appreciation for acute nursing care, how many people it takes and the amount of effort that goes into that.

I'm sensitive to the fact that only 4 percent of the construction budget is allocated for nursing beds, and only 204 hospital beds are scheduled for conversion to nursing beds.

I'm also concerned about the fact that we're seeing this push to contract out a number of services that are vital to health care, and it starts in a very simple manner. We're talking initially plant management, fire protection, and it gets down to housekeeping and finally dietetic services.

It seems to me that these areas are going to affect patient care, and certainly an indication that if this goes unchecked then we're going to have some very primary medical patient care jobs trying to be contracted out.

I am also pleased to see the types of questions that are being raised by the members about consolidation. I simply don't see how you can take all these jobs, divide a portion of the work that's being done in each regional office, somehow consolidate it and get the kind of savings that are being considered.

I think $4 million is a bargain. I think if we had a centralized location for those offices $4 million would be worth it to spread them back out, to get them near the veterans, near where they should be, readily accessible, where we can enjoy due process and the efforts of the Veterans' Administration, and our claims with that agency.

We're concerned with the fact that due process, which is so vital to our organization, could possibly be mitigated by these moves. It was interesting to hear some of the comments that were made by reference to the user fee.

Having spent 2 years as a loan department manager in a Federal savings and loan that dealt very heavily with FHA and VA loans, let me assure you that $29 a month many times can make the difference in the debt load to deny a veteran those services.

And what happens when a veteran pays this off a year or two down the road? Is he going to bear that 4-percent burden? He'll owe more than when he started out. It amounts over the life of the loan to about 15 percent of the initial cost of that house, and I think that if you're going to kill the program then just do it right up front. Don't use insidious back-door manners to deny veterans what's rightfully theirs.

If you're going to do it, let this committee and the Congress say they're going to do it, but not through some budgetary considerations to deny veterans what's rightfully theirs.

I also appreciate the fact, Mr. Chairman, that you alluded to Iwo Jima in your opening remarks. Yesterday I also was fortunate to be a part of a ceremony in recognition of the 40th anniversary of the start of the Battle of Iwo Jima.

The honored speaker there was Lt. Gen. Alfred Gray, who is the Commanding General of the Marine Atlantic Fleet, and he said it's not the fact that we were right, or that right is always going to win out over wrong, or freedom's going to always win out over tyranny.

It wasn't the fact that we had 900 vessels and poured ton upon ton of armament onto that island. The reason that we were victorious there and victorious in the world was because of people, of men and women who were willing to go under very difficult and arduous circumstances and lay their life on the line.

These same people now stand in need of attention by this committee and certainly by the Congress, and we hope that your leadership will go beyond this committee. We don't want to win just the battle, we want to win the war, to see that disabled veterans and veterans in general receive their rightful share of the resources of our country.

I appreciate very much your leadership, look forward to addressing the committee later next week. Thank you.

Chairman MURKOWSKI. Thank you very much. I appreciate your remarks and your entire testimony will be entered into the record.

[The prepared statement of Chad Colley, national commander, Disabled American Veterans, follows:]

PREPARED STATEMENT OF CHAD COLLEY, NATIONAL COMMANDER, DISABLED AMERICAN VETERANS

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 920,000 members of the Disabled American Veterans, I am pleased to appear here today to discuss the budget request of the Veterans Administration for Fiscal Year 1986.

Let me begin by thanking you, Mr. Chairman, and the members of the Committee for soliciting our views on the Fiscal Year 1986 VA budget request prior to submitting your recommendations to the Senate Budget Committee.

As you know, Mr. Chairman, on behalf of the Veterans Administration, the President is requesting $27.1 billion in budget authority to administer the various programs and services for millions of the nation's veterans and their families in Fiscal Year 1986.

In budget authority, the VA request is approximately $123 million below the Fiscal Year 1985 level, primarily due to so-called projected savings that include:

- a 5% reduction in pay for federal employees;
- a decrease in funding for grants to states for construction of extended care facilities;
- implementation of third party reimbursement from private medical insurance policies;
- 1% across-the-board staffing reduction mandated by OMB;
- substantial reduction in construction funds;
- an increase from 1% to 5% in the user fee charged on VA guaranteed home loans.

Overall, Mr. Chairman, these projected savings, coupled with other budget proposals and non-budgetary actions by the Administration, set forth a road map for further decline in the VA's ability to provide continued quality health care and timely claims services to America's veterans.

MEDICAL CARE

The Fiscal Year 1986 budget request calls for an overall funding increase in the VA's medical care account of $235 million--an upward adjustment of approximately 2.6%--over the Fiscal Year 1985 level.

According to budget documents, this increase will provide 199 additional health care employees; treat 112,000 more veterans on an outpatient basis and 3,211 inpatients; and permit 204 hospital to nursing home bed conversions.

While these documents may indicate an increase in funding for the VA medical care account, upon closer examination it becomes clearly evident that for the current fiscal year and Fiscal Year 1986 VA bed levels and employees will, in fact, decline below that which has been mandated by law or previously authorized by the Congress.

Mr. Chairman, OMB and the VA have circumvented the law. In Fiscal Year 1985 VA will operate with 600 fewer beds than that which is required by Section 5010(a)(1) of Title 38, U.S. Code and in Fiscal Year 1986 bed levels will drop 900 below statutory requirements.

The HUD and Independent Agencies Appropriations, Fiscal Year 1985--Public Law 98-371--provided support specifically intended for 193,941 full time equivalent VA health care employees and the Comptroller General of the United States has confirmed that OMB has provided the funds and personnel ceiling appropriated by the Act.

Yet the VA says, "the agency now projects that the budgeted work loads can be achieved with an employment level of 191,849." At the same time, however, their own statistics reveal they are turning away more than a quarter of a million eligible veterans who are seeking VA health care services each year.

We must question, Mr. Chairman, why the VA or OMB has not informed the Congress that funding was insufficient to operate beds and provide employees at levels authorized or required by law? Or does OMB and VA have another reason for their failure to adequately and promptly inform the Congress of any shortfall in funding? Certainly, OMB has made it perfectly clear that they would like "to shrink the size of the system"--but shrink it to what, we ask?

As you know, Mr. Chairman, the VA health care system has been on the decline for a number of years due to negative (deflated) funding growth of the system. The proposed Fiscal Year 1986 medical care budget is no different than those of the past ten years. For example, last year's budget request for medical care fell 3.5% below the cost of health care in the private medical community and this year's request is again 3.5% below that which was experienced in the private sector during the same period.

Straight-line funding (in terms of real growth) coupled with such proposals as 5% pay reductions; across-the-board staffing reductions; cancelling nurses' scholarships under the Health Professional Scholarship Program; collecting reimbursements from private health insurers of nonservice-connected veterans receiving VA care; repealing the provision of Title 38, U.S. Code that gives veterans age 65 and over eligibility to VA hospital care; and establishing a means test for nonservice-connected veterans seeking VA care are further indications of OMB's real effort--destroy the VA health care system.

For example, collecting reimbursements from the private health insurers of nonservice-connected veterans receiving VA health care services is a rehash of an old idea that has time and again been rejected by the Congress.

Today, OMB estimates VA can collect $65 million from these private health insurers, while four years ago they said they could collect over $300 million. VA officials have publicly stated that they nor OMB have any sound basis for making such an estimate for this proposal.

Given the fact that most private health insurance policies provide exclusionary clauses prohibiting third party payments to the government, as well as the fact the vast majority of nonservice-connected veterans seeking health care from the VA have no private health insurance coverage, makes these collection estimates highly speculative. Then, if you include the added administrative expenses of collecting these payments, you end up with a proposal that could cost, rather than save, the government money.

Additionally, they propose to accomplish a "comprehensive reform of VA medical care eligibility" by (1) repealing Section 610(a) of Title 38, U.S. Code--providing eligibility for hospital or nursing home care to any veteran for a nonservice-connected disability if the veteran is 65 years of age or older--and (2) establishing a means test for certain categories of veterans without service-connected disabilities and without regard for age.

It is interesting to note that the Administration is only now proposing a means test that they were directed by the Congress to accomplish some four years ago.

Quite frankly, Mr. Chairman, the VA could develop a fair and equitable means test and the Congress could repeal Section 610(a) of Title 38, U.S. Code. The end result would be that nonservice-connected veterans with private health insurance would not be admitted to VA medical centers--thus, there would exist little, if any, need for third party reimbursement legislation.

Even if all this is accomplished, we believe that there will be a veteran to fill every bed vacated by those displaced by the proposed legislation.

One final point, Mr. Chairman, coinciding with the recent release of the VA's proposed Fiscal Year 1986 request, the DAV learned that OMB has directed the VA to accelerate plans to contract out positions within the VA health care system to the private sector.

As we understand it, OMB is seeking to eliminate some 30,000 jobs within the health care system over the next five years. Positions that are being scrutinized for possible contracting out include areas such as dietetic services, fire protection, plant maintenance and housekeeping.

As you know, Mr. Chairman, this Committee and your counterpart in the House has, by law, prohibited the VA from contracting out any positions that directly relate to patient care. In our view, many of the jobs under consideration are, in fact, directly related to patient care and, as such, should be exempted from any contracting out review.

This is just another avenue being used by OMB to thwart the will of Congress and erode the VA health care system. We believe the funding associated with A-76 studies contained in the Fiscal Year 1986 budget could be put to better use--that is, providing care to veterans.

Mr. Chairman, we encourage you and the members of the Committee to carefully scrutinize the Fiscal Year 1986 funding levels proposed for the VA medical care account. We believe such scrutiny will lead you to recommend to the Senate Budget Committee realistic levels of funding that will acknowledge the growing demand that has been and will continue to be placed upon the VA's medical care system. And, should the Congress not impose the 5% pay reduction for federal employees, as proposed by the President, we respectfully request the VA health care system be exempted from absorbing the funds associated with the proposed legislation.

CONSTRUCTION

The VA's Fiscal Year 1986 construction request is $156.8 million below the Fiscal Year 1985 level. However, the VA proposes to reprogram $160 million in prior budget authority from the major working reserve to bring the program level to $771.6 million.

Mr. Chairman, while we support full funding of the VA's request for construction programs, we are nevertheless concerned, as I mentioned earlier, over the VA's effort to meet the pressing demands on the health care system.

As you know, greater numbers of elderly veterans are seeking nursing home care from the VA, yet, of this construction budget proposal less than 4% is requested for nursing home care bed construction. We have noted and support the VA's proposal to convert 204 hospital to nursing home care beds, as well as their efforts to replace and modernize its older facilities. However, we trust an appropriate balance will be maintained to meet the acute and intermediate health care needs of our aging veteran population.

Finally, the VA's Fiscal Year 1986 request contains a $12.5 million decrease (under the Fiscal Year 1985 level) in grants for construction of state extended care facilities. The VA's request of $22 million will provide for an additional 450 nursing home care beds and 126 convertible domiciliary/nursing home beds.

As you know, Mr. Chairman, this program has been a tremendous success in terms of encouraging states to actively participate in the nation's commitment to providing quality health care to her eligible veterans. In our view, it is shortsighted to cut funds in a program that ultimately makes savings to the government in terms of both construction and health care costs.

DEPARTMENT OF VETERANS BENEFITS

The Department of Veterans Benefits' Fiscal Year 1986 budget request is down by more than $4 million and 624 employees, compared to Fiscal Year 1985 levels.

According to budget documents, the 624 average employment reduction in DVB personnel is attributed to consolidation of certain regional office activities, declining work loads and management actions to reduce overhead and increase productivity.

As you know, Mr. Chairman, in 1981, this Administration first suggested the idea of consolidating all regional office activities into a number of super regional offices throughout the United States. For many good reasons that proposal was soundly rejected by the Congress.

Now, in 1985, this Administration again comes forth with a similar proposal to consolidate only adjudication of compensation, pension and education claims (including Rating Boards), loan processing, finance, administrative and personnel functions into three regional centers. This proposal would leave veterans' assistance, compliance survey, vocational rehabilitation and counseling, loan servicing, property management, and construction and valuation activities at each existing regional office, thus, relegating these facilities to nothing less than contact offices that provide general information, counseling and forward claim inquiries to the three regional centers.

Quite frankly, Mr. Chairman, we view this proposal, as we did in 1981, as bureaucracy at its absolute worst.

Since 1980, nearly 4,000 employees have been slashed from the Department of Veterans Benefits and, today, each regional office is barely staffed at minimal levels to handle the work load and demand for services from veterans and their dependents.

Consolidation of these already understaffed functions will not only worsen the delays veterans currently experience with respect to claims processing, but deprive them of direct access to the system. For example, no longer would veterans and their dependents have the opportunity for a timely, face-to-face hearing (within a reasonable proximity of their home) with a VA Rating Board and their appointed representative.

And, quite frankly, the proposal makes absolutely no economic sense whatsoever. Millions of dollars would be required to relocate employees, obtain office equipment, acquire huge amounts of office space and train new employees (to replace those who did not relocate).

Mr. Chairman, the DAV strongly urges you and the members of the Committee to soundly reject this poorly conceived plan, redirect the $25.1 million the Administration is requesting to implement the plan and restore the 624 DVB employees desperately needed by the regional offices to improve services to veterans and their dependents.

PROPOSED LEGISLATION

The Administration's Fiscal Year 1986 budget request proposes legislation that would provide for (1) an increase of 4.1% in the rates of disability compensation and Dependency and Indemnity Compensation (DIC) effective December 1, 1985; (2) increase from 1% to 5% the loan origination fee on all guaranteed and vendee loans; (3) allow for borrower/lender negotiated rates on guaranteed and vendee loans (mortgages), and terminate the Administrator's authority to set interest rates; (4) repeal transfer authority from direct loan revolving fund to the loan guaranty revolving fund; (5) repeal the authority that permits the VA to make education loans; and (6) to effect reimbursement from third party insurance carriers for the cost of care and treatment of nonservice-connected veterans (to which I addressed our concerns earlier).

The DAV is pleased with the Administration's proposed cost of living adjustment in the rates of disability compensation and DIC benefits--in recognition of the special consideration service-connected disabled veterans and their survivors should be given.

Accordingly, Mr. Chairman, the DAV supports the enactment of legislation that would provide disability compensation and DIC recipients with a cost of living adjustment in line with the rise in the Consumer Price Index effective December 1, 1985.

As noted, the Administration has proposed several legislative changes to the current VA Home Loan Guaranty Program. Of particular concern to most veterans are the proposals that would increase the user's fee from 1% to 5% and remove the Administrator's authority to set the interest rates for such home loans.

Quite frankly, these two legislative initiatives appear to be sufficient to effectively destroy the VA Home Loan Guaranty Program. Yet, the Administration is projecting 250,000 loans will be generated next year by this program.

Mr. Chairman, why would a quarter of a million veterans fork over $3,000 to $5,000 just for the privilege of using this program, while not one nickel will reduce the principal of their mortgage? How much would they pay for this privilege over 25-30 years?

Coupling this exorbitant user's fee with the removal of the interest rate ceiling nearly eliminates any benefit to veterans. We believe the Committee should carefully evaluate the adverse impact these proposals will have upon the Vietnam veterans who are the primary beneficiaries of the program today and, should they be rejected, we respectfully request that the Department of Veterans Benefits be exempted from absorbing the funds associated with the proposed legislation.

VETERANS' EMPLOYMENT PROGRAMS

Mr. Chairman, we have also reviewed the proposed budget for veterans' employment and training programs administered through the office of the Assistant Secretary for Veterans' Employment and Training.

The Administration has proposed $12.6 million, providing 282 staff positions for the office of the Assistant Secretary for Veterans' Employment and Training. While this represents a slight decrease in the total dollar amount, it still proposes to fund the same 282 positions it did for Fiscal Year 1985.

As you know, the office of the Assistant Secretary for Veterans' Employment and Training now has the responsibility for distributing the funding for the Disabled Veterans Outreach Program (DVOP) and the Local Veterans Employment Representative (LVER) program. In this regard, the 1986 budget proposes $60,845,000 and $50,641,000 for the DVOP and LVER programs, respectively. While the overall dollar amounts are slightly increased, the number of positions for DVOP and LVERs decreases from the Fiscal Year 1985 level.

Mr. Chairman, we must express our concern for the continued employment services provided to veterans by DVOP and LVER personnel.

As you know, the state employment security agencies during the last four years have lost approximately 33% of their staff. While DVOP personnel are not counted as part of that staff, the LVER personnel are included. Therefore, with the overall decline in personnel system-wide, we fear reduced services to eligible veterans seeking assistance from DVOP and LVER personnel.

CONCLUSION

In closing, Mr. Chairman, in addition to the views we have already set forth with respect to the VA's proposed Fiscal Year 1986 budget request, I want to emphasize that the main reason this budget request is below the Fiscal Year 1985 level--and still provides for a cost of living adjustment in compensation, DIC and pension benefits, as well as adding funding to the VA health care program--is due to unrealistic legislative proposals crafted by the Administration.

Therefore, we urge the Committee to favorably recommend to the Senate Budget Committee restoration of the levels of funding deleted by these unrealistic proposals, thereby providing the VA with funding that adequately addresses the needs of those programs administered by the VA.

Again, I wish to thank you and the members of the Committee for allowing us this opportunity to express our views on this most important subject.

Chairman MURKOWSKI. I might just generally comment on the general tone. I appreciate and respect your attitude toward the administration's particular point of view.

I would appreciate your recommendations on how we can do better with what we have, because obviously you, sir, have experienced within your lifetime an extraordinary sacrifice for your country.

And you and those who represent your organization, I would think, would have some very constructive recommendations for the VA and for this committee, and I would appreciate anything you would care to provide for the record.

Mr. COLLEY. This defines some very simple solution, and therefore for me to shoot from the hip or ad-lib would be ludicrous. We'd be more than happy, to discuss with your staff some proposals.

We wish we had the total solution, but it's very complex. We have some very closely felt and held ideas that we'd be happy to discuss with the committee staff, and we want something that we can support. We want a budget that we can support, that we can encourage our people to accept that which we cannot have, and those areas in which we must learn to do with less. We want a budget that's fair and equitable, and with your help we'll do our part to see that we get it.

Chairman MURKOWSKI. Thank you. I assure you of my commitment to work with you, and I look forward to whatever input you have—because ultimately, after this whole process is complete, we are going to have a specific amount to work with, whatever that ultimately is.

The question is, can we do a better job with that, and I think we're both on the same wavelength and have the same interest in doing that.

Mr. COLLEY. Thank you, sir.

Chairman MURKOWSKI. Thank you very much. We appreciate that, Mr. Colley.

Let me ask one more. This continually comes up. I am a veteran and a member of the VFW, but I'm not a combat veteran, so I can't speak from first-hand experience.

I was in between two wars, and between the Korean war and the Vietnam war, but I think there's a general feeling in this country that the disabled combat veterans are the ones that the country has a higher obligation to. Maybe that's a philosophical feeling.

In your view, is it equitable that the nondisabled combat veteran has a lower priority for health care than a veteran who has never served in combat, but who has been rated service connected for a disability that is unrelated to his or her military duties, such as an accident that occurs off base?

Mr. COLLEY. There are a number of ways that that question could be addressed.

Chairman MURKOWSKI. Well, please pick one of them.

Mr. COLLEY. I appreciate the fact that the Administrator said, if you recall, it was his contention that all veterans who had severe disability would receive and are receiving suitable care under the VA, and that will not be done, has not been done at this point, to the detriment of other needy combat veterans.

Therefore I know personally I have never, ever felt that I was—that I did not receive anything that I needed, any assistance or anything of any type because other veterans who were receiving treatment for disabilities might not have had them incurred in battle.

I am not convinced that our country cannot accommodate all disabled veterans within the resources that are allocated.

Chairman MURKOWSKI. That has been the case so far.

Thank you very much, Mr. Colley. We look forward to your appearance here again in, what, another week?

Mr. COLLEY. Another week.

Chairman MURKOWSKI. Thank you very much. I look forward to your visit.

[The responses of the Disabled American Veterans to written questions submitted by Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs, and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

RESPONSE OF THE DISABLED AMERICAN VETERANS TO WRITTEN QUESTIONS SUBMITTED BY HON.

FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1. There has been much discussion on the proposed 5% fee for the VA's Home Loan Guaranty Program. The bottom line is that the Loan Guaranty Revolving Fund (LGRF) is bankrupt. An alternative to increasing the funding fee is an annual appropriation approaching one half billion dollars. This seems unrealistic in light of soaring deficits and competing needs of health care and other VA programs.

What specifically do you believe should be done to rejuvenate this program and to make it self-sustaining once again?

Answer 1.

Charging veterans 5% to use the VA Home Loan Guaranty Program is not, in our view, the prescription that will heal the ills of the VA Loan Guaranty Revolving Fund. Furthermore, just last year the Deficit Reduction Act of 1984--Public Law 98-369--addressed the dilemma of the Loan Guaranty Revolving Fund. That legislation increased the fee from .5% to 1.0%, required the fee to be deposited in the Revolving Fund and extended authority to collect the fee through September 30, 1987. In addition, this legislation required collection of the fee on all vendee loans and limited the circumstances under which foreclosed properties may be conveyed to the VA. These various provisions of Public 98-369 went into effect at different times during the past six months and, quite frankly, it doesn't appear that sufficient time has elapsed to determine the effect these changes will have upon the VA Loan Guaranty Revolving Fund. Therefore, the DAV supports funding (should that be necessary) of the Revolving Fund until such time as the real impact of Public Law 98-369 is known.

Question 2. Please comment on the merits of co-locating VA Regional Offices on the site of VA Medical Centers.

Answer 2.

As you know, the VA currently has a number of regional offices located on the sites of medical centers. The DAV has no objections in those instances where veterans will be served as equally well and taxpayer dollars can be saved through co-locating of VA regional offices with medical centers. We would not, however, favor any proposal that anticipates a loss of either medical services, existing beds or closure of medical facilities in order to accommodate the activities of a regional office.

Question 3. If the Congress were to support an across-the-board COLA freeze for recipients of all federal benefits, would your organization support this approach for VA compensation and pension?

Answer 3.

The DAV would not object to an even-handed, across-the-board freeze on all federal expenditures.

Question 4. Veterans reaching the age of 65 are presumed to be totally and permanently disabled for purposes of eligibility for nonservice-connected pension, although veterans reaching the age of 65 are not necessarily totally disabled. I would appreciate having your thoughts on whether it would be advisable to remove the legal presumption which equates age with disability and provide pension only to veterans who actually are totally disabled.

Answer 4.

As you know, current law directs the VA to presume a veteran to be permanently and totally disabled at age 65 for nonservice-connected pension purposes. Yet, Title 38, U.S. Code does not extend a similar presumption (for compensation purposes) to service-connected disabled veterans. Furthermore, Section 4.19, 38 CFR states very specifically that, "age may not be considered as a factor in evaluating service-connected disability; and unemployability, in service-connected claims, associated with advancing age or intercurrent disability, may not be used as a basis for a total disability rating." The DAV believes such dissimilar criteria between the compensation and pension programs for determining permanent and total disability should not exist.

Question 5A. Do veterans who use Vet Centers need services other than psychological counseling to aid them in this readjustment?

Answer 5A.

Generally speaking, veterans seeking the counseling services available at each Vet Center are in need of other services offered by the VA that would assist them with their readjustment problems--services which are not now available at each Vet Center.

Question 5B. If so, do you think my proposal to add drug and alcohol counseling, employment training and placement, and education and rehabilitation services would be useful?

Answer 5B.

Certainly the availability and coordination of existing VA drug and alcohol counseling, employment training and placement, and education and rehabilitation services for veterans utilizing the Vet Centers would greatly enhance their possibilities for successful readjustment.

Question 6. Since we have to make hard choices about where to save money this year, could you comment on the relative priority of allocating dollars to staff and hospitals versus beneficiary travel payments?

Answer 6.

The DAV has no (official) position.

Question 7A. If the Congress adopts third party reimbursements for VA medical care, what is the rationale for excluding from this proposal service-connected veterans who seek treatment for nonservice-connected disabilities?

Question 7B. If veterans already have medical insurance, why would using that insurance to pay for their care for nonservice-connected disabilities be different than using insurance paid for by nonservice-connected veterans?

Answers 7A and 7B.

The DAV is adamantly opposed to all third party reimbursement proposals. However, Mr. Chairman, I believe it is important to point out that this type of proposal has been rejected by the Congress on several occasions in the past and, quite frankly, we firmly believe it will again be rejected.

Question 8A. What are your views on the current prioritization for VA medical care?

Question 8B. Do you have any thoughts or suggestions about how, or if, the current system could be improved to provide combat veterans with a priority for medical care services commensurate with their sacrifices?

Answers 8A and 8B.

The DAV finds the current system of priorities for medical care adequately meeting the needs of eligible veterans seeking care from the VA.

RESPONSE OF THE DISABLED AMERICAN VETERANS TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

In connection with the A-76, contracting out process, please indicate whether you support or oppose VA hospitals' contracting out for food services, for fire protection, for plant maintenance and for housekeeping, and why.

Answer 1.

As I stated in my testimony of February 20, 1985, the DAV is seriously concerned about OMB's efforts to accelerate plans for contracting out positions within the VA health care system to the private sector. Quite frankly, we believe OMB is using this effort to further its overall goal to shrink the size of the VA health care system.

Contracting out of such services as housekeeping, food services, plant maintenance or fire protection would, in our judgement, jeopardize the welfare and safety, as well as the quality of health care veteran patients currently receive in VA medical facilities.

Question 2.

Please let me have your organization's views on the proposal put forward by the Vietnam Veterans of America to establish a commission -- along the lines of the so-called "Bradley Commission" -- to conduct a comprehensive review of veterans' programs.

Answer 2.

The DAV would vigorously oppose any such effort. The idea, in our view, is preposterous and flies in the face of the rigorous oversight of veterans' programs by:

1. Congress in connection with the Budget and Appropriation Process;
2. The Veterans Affairs Committees pointed investigative oversight functions with respect to reconciliation instructions to make cuts or reduce overall veterans' spending;
3. The Office of the Veterans Administration Inspector General; and
4. Official and unofficial commissions and foundations of the private sector.

Chairman **MURKOWSKI**. We have one more panel now: Mr. David Passamaneck, national legislative commander of AMVETS; my friend Mr. Jack Powell, executive director of the Paralyzed Veterans of America; and Mr. Robert Muller, president of the Vietnam Veterans of America, who will be accompanied by Mr. Dennis Rhoades, executive director of the Vietnam Vets.

I guess we're going to start with Mr. David Passamaneck, the legislative commander at AMVETS.

Colonel **PASSAMANECK**. That's "Director." I——

Chairman **MURKOWSKI**. That's a good Irish name.

Colonel **PASSAMANECK**. I'd like to be "commander" some day, but so far I'm only the director. [Laughter.]

Chairman **MURKOWSKI**. Oh, well, that's all right. Just go into—Government work.

TESTIMONY OF A PANEL OF REPRESENTATIVES OF VETERANS' ORGANIZATIONS CONSISTING OF DAVID J. PASSAMANECK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS; R. JACK POWELL, EXECUTIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; AND ROBERT O. MULLER, PRESIDENT, VIETNAM VETERANS OF AMERICA, ACCOMPANIED BY DENNIS RHOADES, EXECUTIVE DIRECTOR

Colonel **PASSAMANECK**. Mr. Chairman, I request that my preprinted prepared remarks be included in the record.

Chairman **MURKOWSKI**. It's included in the record.

Colonel **PASSAMANECK**. I will endeavor at this point to summarize those remarks.

AMVETS is most pleased to be appearing before this distinguished committee for the first time, with you, Mr. Chairman, presiding. We anticipate a positive, rewarding relationship with the committee and staff in the interest of America's veterans.

Last year, in our testimony before the Senate and the House committees on the 1985 VA budget, we stated:

> The recurrent practice of this Administration of grouping veterans' programs with other so-called middle-class entitlements is not only insulting to veterans, but completely inconsistent with the President's obvious sincere concern for the condition of our defense posture. In this connection, the handwriting is on the wall in this budget, with the ominous warning that in order to minimize the need for future tax increases, veterans' programs will be subject to "intensive scrutiny."

We are now seeing the results of "intensive scrutiny."

Regarding the VA budget, the administration has begun its massive assault on budget deficits by seeking to undermine the basic structure of the VA health-care system, the underlying concept of compensation and pension, and the highly successful Loan Guaranty Program.

In other words, with Mr. David Stockman, the young man who avoided military service during the Vietnam war, molding policy, veterans are to be treated as if they have no special claim on the resources of a society which their valor and sacrifice has preserved.

Veterans' programs—"sacred cows," as Mr. Stockman described them recently—are to be regarded as no more justified than other so-called "domestic" items in the budget.

The obvious fact that veterans' entitlements are a justified, continuing cost of war and a clear signal of a government's regard, or lack thereof, for those who defend its people from foreign enemies has not penetrated the minds of the bookkeepers in the Office of Management and Budget.

The proposed 1986 budget for the Assistant Secretary of Labor for Veterans' Employment and Training is generally acceptable, with an overall increase of almost $2 million. There are, however, some disturbing decreases in service, particularly affecting Vietnam and disabled veterans.

We do not agree with the projected total of Disabled Veterans' Outreach Program personnel, resulting in a $1,196,000 decrease. And we do not concur in the projected reduction in workload, resulting in a decrease of $1,864,000 for LVER positions.

The projected degradation in the GS-11 through GS-15 range and the planned consolidation of field functions threatens a parallel degradation in the quality of employment services for veterans.

We should keep a watchful eye on these cuts from the standpoint of the veteran, rather than the Federal deficit alone.

We are also concerned about the decrease in title IV C funding for handicapped employment as it may affect veterans.

When budgets are to be cut, Mr. Chairman, national defense and veterans should come last, not first. An effective defense policy is simply not possible if those who serve in the military are treated with contempt.

Regardless of how any of us may stand on the issue of taxes, budget restraint, or the relative importance of social programs, we should have no trouble agreeing on the priority of veterans' entitlements. Thank you.

Chairman MURKOWSKI. Thank you very much.

[The prepared statement of David J. Passamaneck, national legislative director, AMVETS, and AMVETS' responses to written questions submitted by Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs; and Hon. Alan Cranston, ranking minority member of the Senate Committee on Veterans' Affairs, follow:]

PREPARED STATEMENT OF DAVID J. PASSAMANECK, NATIONAL LEGISLATIVE DIRECTOR, AMVETS

AMVETS is most pleased to be appearing before this distinguished Committee for the first time with you, Mr. Chairman, presiding. We anticipate a positive and rewarding relationship with the Committee and staff in the interest of America's veterans.

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We are now seeing the results of the "intensive scrutiny," which, as promised by the Office of Management and Budget, are being revealed after the elections. The most outstanding characteristic of the 1986 VA Budget, which is approximately $100 million less than last year, is that it represents the first turnaround in a policy of gradual, but steadily improving entitlements and services for veterans and their dependents since the depression of the 1930's. The apparent solution, as far as the Administration is concerned, for the impending 40% increase in veterans 65 and over by the year 2000, with the attendant need for intense development of geriatric care systems, is to cut the heart out of the VA medical program with the immediate objective of removing all but service connected disabled from the rolls of those eligible for VA medical care, and ultimately to provide such care for combat and instrumentality of war disabilities only. This objective was clearly set forth in the concluding discussion on the VA in the by now notorious report of the President's Private Sector Survey on Cost Control (the Grace Commission) whose Chairman, J. Peter Grace, is also the Chief Executive Officer of one of the largest private suppliers of nursing home and other medical services. The same policy objective was reaffirmed by recent White House inquiries of the VA regarding the expected work load if health benefits were limited to veterans with service-connected disabilities.

In addition to recommending a cut of over $150 million in construction funding mostly for improvements to inadequate medical facilities, on the inspiration of David A. Stockman, the Director of OMB, the Administration is seeking legislation to cancel the current space available entitlement to medical care for veterans 65 and older, regardless of economic need, and require all nonservice-connected veterans who were not POW's, and who are not on the pension rolls to pass what amounts to a pauper's test in order to receive medical treatment from the VA. The specific conditions of this so called "means test" remain to be seen, but one version would have veterans paying for the care. No one can say what the limit of these charges would be, but one thing is sure: Millions of sick, elderly veterans would be turned away from VA clinics and hospitals. This same David Stockman, who, in his approach to the budget has demonstrated unmitigated contempt for veterans and retired military is the young man who enrolled in Harvard Divinity School during the Vietnam war in order to avoid military service. In other words, this draft dodger is now leading the assault on military personnel entitlements and veterans programs on behalf of a President who otherwise appears to be sincerely interested in bolstering our national defense posture. As we pointed out when the Grace report was released, even if it could be argued that destruction of the VA medical system, at least as we know it, would save government money, that saving would be at the cost of a revolting betrayal of those of our citizens who have made the most sacrifices for the very survival of our nation. But the tragic irony of the matter is that if the Grace Commission recommendations are followed, health care for veterans on a per capita basis would go up over 10%. Hence, the desire to cut most veterans out of the system.

When confronted with serious questions posed by AMVETS and other veterans groups regarding the cost of implementing the suggested "means test" at the VA's briefing on the budget, the leadership of the VA shrugged their shoulders in bewilderment, but made it clear that the cost of driving millions of elderly veterans from VA facilities would, indeed, be tremendous. Of course, no mention was made of the veterans who, discouraged by the abuse and red tape which would be involved in enforcing the "means test," simply would not even attempt to seek necessary, often preventive treatment to stay the onset of degenerative geriatric conditions. To further impair the ability of veterans to secure adequate health care, the budget also calls for intensive third party collection from insurers, with the resulting sharp increase in premiums and restriction in coverage.

In addition to a proposed destruction of the VA medical system, which would soon disappear without a sufficiently broad patient base, supported by a world class research program, the Administration also seeks to drive millions of veterans from the ranks of home owners by increasing the loan guarantee funding fee from 1 to 5%. This is another brilliant suggestion of the Grace Commission, which will effectively eliminate the no down payment purchase of homes by veterans, or drastically increase the rates of foreclosures.

The plans for the Department of Veterans Benefits, those people with whom the veteran deals in the determination of almost all his entitlements, call for slashing over 4 million dollars and about 700 employees. Also, if the budget cutters have their way, the Regional Offices, as we know them, will be eliminated, leaving in their places some 59 contact offices, with the adjudication, loan guaranty, rating and other administrative functions removed to 3 regional centers. In other words the bureaucracy will be made even more impersonal, with the attendant delays, uncertainties and hardships impacting on the veterans. Hundreds of employees will be removed from most states, and those who do not wish to be uprooted will lose their jobs. The requested appropriation for this consolidation for 198[illegible] is $25,000,000.

Although the Administration proposes a 4.1% cost-of-living increase for compensation and pension, at the same time it seeks to completely undermine the basic quality of VA compensation and pension by subjecting them to the tender mercies of income taxation. The same absurd proposal has been suggested for military disability retirement pay, even for those currently entitled to tax free pay. We commend Administrator Harry Walters for his courageous opposition to this monstrous scheme.

The proposed 1986 Budget for the Assistant Secretary of Labor for Veterans Employment and Training is generally acceptable, with an overall increase of almost $2 million. There are, however, some disturbing decreases in service, particularly affecting Vietnam and disabled veterans. We do not agree with the projected total of Disabled Veterans Outreach Program personnel, resulting in a $1,196,000 decrease and we do not concur in the projected reduction in work load resulting in a decrease of $1,864,000 for LVER positions.

The projected degradation in the GS-11 - 15 range, and the planned consolidation of field functions threatens a parallel degradation in the quality of employment services for veterans. We should keep a watchful eye on these cuts from the standpoint of the veteran, rather than the federal deficit alone. We are also concerned about the decrease in Title [illegible] funding for handicapped employment as it may affect veterans.

AMVETS enthusiastically supports the President's policies regarding the stimulation of the private economy through lower taxes and less government spending in areas where government has no business intruding. National defense, most definitely including the cost of military personnel, active and retired and the cost of veterans programs is one area where government does have a basic and historic responsibility. When we cut expenditures, the last thing we should do is cut them in this area.

RESPONSE OF AMVETS (AMERICAN VETERANS OF WORLD WAR II, KOREA AND VIETNAM) TO WRITTEN QUESTIONS SUBMITTED BY HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

There has been much discussion on the proposed 5 percent fee for the VA's home loan program. The bottom line is that the Loan Guaranty Revolving Fund (LGRF) is bankrupt. An alternative to increasing the funding fee is an annual appropriation approaching one-half billion dollars. This seems unrealistic in light of soaring deficits and competing needs of health-care and other VA programs.

What specifically do you believe should be done to rejuvenate this program and to make it self-sustaining once again?

Answer 1.

AMVETS is opposed to raising the placement fee from 1 to 5%. If additional appropriations are required, we favor their enactment. We regard the home loan guarantee program as an earned entitlement and not a business venture.

Question 2.

Please comment on the merits of co-locating VA Regional Offices on the site of VA Medical Centers.

Answer 2.

Co-locating VA Regional Offices with Medical Centers, so long as optimum access in all states is assured, and administration requirements of the Regional Offices do not suffer is a good idea. In such a co-location, we would expect that adequate space and facilities would be provided for representatives of chartered service organizations.

Question 3.

If the Congress were to support an across-the-board COLA freeze for recipients of all Federal benefits, would your organization support this approach for VA compensation and pension?

Answer 3.

No! Veterans entitlements are not of equal worth with other Government transfer payments. Veterans come first!

Question 4.

Veterans reaching the age of 65 are presumed to be totally and permanently disabled for purposes of eligibility for non-service-connected pension, although veterans reaching the age of 65 are not necessarily totally disabled. I would appreciate having your thoughts on whether it would be advisable to remove the legal presumption which equates age with disability and provide pension only to veterans who actually are totally disabled.

Answer 4.

For those relatively few veterans whose income is so low as to qualify them for pension, I think we can afford a little compassion. The administrative cost of determining the degree of disability of indigent veterans over 65 would outway the saving resulting from removal of the presumption of total disability.

Question 5.

A. Do veterans who use Vet Centers need services other than psychological counseling to aid them in this readjustment?

B. If so, do you think my proposal to add drug and alcohol counseling, employment training and palcement, and education and rehabilitation services would be useful?

Answers 5A and 5B.

They need general information and red tape cutting, as well as a friendly phone call to open a door here and there.

Your proposal to add drug, alcohol counseling and employment and rehabilitation services has great merit.

Question 6.

Since we have to make hard choices about where to save money this year, could you comment on the relative priority of allocating dollars to staff and hospitals versus beneficiary travel payments?.

Answer 6.

The quality of medical service will suffer with insufficient funding of staff and hospitals. The recipients of that medical service will suffer if they cannot afford to go to the hospital. Both requirements are important.

Question 7.

A. If the Congress adopts third party reimbursements for VA medical care, what is the rationale for excluding from this proposal service-connected veterans who seek treatment for non-service-connected disabilities?

B. If veterans already have medical insurance, why would using that insurance to pay for their care for non-service-connected disabilities be different than using insurance paid for by non-service-connected veterans?

Answers 7A and 7B.

> Enforcement of third party reimbursement will cause carriers to raise their rates and exclude veterans from coverage, thus driving more veterans to VA hospitals for nonservice-connected care.

Question 8.

A. What are your views on the current prioritization for VA medical care?

B. Do you have any thoughts or suggestions about how, or if, the current system could be improved to provide combat veterans with a priority for medical care services commensurate with their sacrifices?

Answers 8A and 8B.

> We are satisfied with the current priority system for entitlement to VA medical care. We are opposed to a narrowing of the category of service connection to exclude all but instrumentality of war or armed conflict related disabilities which would surely result from instituting that differentation into the system. Narrowing the concept of service connection is one of the Grace Commission's recommendations.

RESPONSE OF AMVETS (AMERICAN VETERANS OF WORLD WAR II, KOREA AND VIETNAM) TO WRITTEN QUESTIONS SUBMITTED BY HON. ALAN CRANSTON, RANKING MINORITY MEMBER OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1.

In connection with the A-76, contracting out process, please indicate whether you support or oppose VA hospitals' contracting out for food services, for fire protection, for plant maintenance, and for housekeeping, and why.

Answer 1.

Experience has proved that, despite apparent initial contractural cost savings under A-76, within one or two years after dissolution of governmental infrastructures of qualified employees, costs begin to rise well above direct employment levels. Experience has also proved that contracting out results in wholesale discharge of veterans, serious impairment of employment morale in general and destruction of the esprit de corps necessary for providing dedicated service to hospitalized veterans. Although it has been argued that contract compliance procedures would guarantee veterans preference in contractor hiring, we have never been able to successfully overcome the pleas of contractors that they could not find enough qualified veterans to fill their needs, thus circumventing veterans preference. AMVETS, in accordance with the mandate of our 40th National Convention, thus opposes A-76 contracting out for food service, or any other purpose in VA hospitals, or in the government in general.

Question 2.

Please let me have your organization's views on the proposal put forward by the Vietnam Veterans of America to establish a commission - along the lines of the so-called "Bradley Commission" - to conduct a comprehensive review of veterans' programs.

Answer 2.

AMVETS would view with considerable scepticism the establishment of a "Bradley" type commission to conduct a "comprehensive review of veterans' programs." The most stated justification for such a commission would be its presumed objectivity in analyzing veterans programs. We are not so naive as to believe that anyone can be neutrally objective on the subject of government spending for veterans or otherwise. In any event, the informed activists in the field of veterans' affairs from government, veterans organizations and private business who will, of necessity, comprise such a commission, will all have pronounced points of view on the subject, if not "bones to pick." Moreover, we see no value in the creation of yet another monstrous bureaucratic organ with an even more monstrous staff of high paid wordsmiths. We also suspect that the establishment of such a commission would be used by anti-veteran elements to justify the dismantling of the VA medical system in accordance with the recommendations of the Grace Commission and the Heritage Foundation. One Grace Commission has been quite enougn.

It is obvious that for reasons which remain obscure, Mr. Bobby Muller, President of the VVA, the man who laid a wreath on the grave of Ho Chi Minh, has crawled into bed with David Stockman and the Grace Commission. Maybe he wants to be Chairman of the new "Bradley Commission" which would, of course, be called the "Muller Commission."

Chairman MURKOWSKI. The next witness, Mr. Powell.

Please proceed, Mr. Powell——

Mr. POWELL. Yes, Mr. Chairman.

Chairman MURKOWSKI [continuing]. Executive director of the Paralyzed Veterans of America.

Mr. POWELL. We want to take this opportunity to welcome you, Senator, as the chairman of this committee.

I hope that this committee proves as successful and rapid a success pattern for you as it did for its previous chairman.

PVA recognizes the need to reduce the Federal deficit. But in examining the proposed fiscal year 1986 VA budget, we find the targeting of veterans' health care and services to be a reprehensible approach and a disservice to the men and women who served the Nation.

Last year, when we came before this committee, we said that the proposed 1985 budget will generally preclude the diminution of VA programs. Unfortunately, this year we're not able to say that, and we are somewhat surprised and astounded that the same administration who, 1 year ago, said that fiscal year 1986 for veterans' programs would cost $28.4 billion, says this year they can do the same thing for $27.1 billion; and says not only that but next year, as opposed to their $29.580 billion that they said that they needed, they're going to be able to do it for $27 billion 400 million.

These are truly astounding, if they are, in fact, real productivity gains.

This year's budget proposal doesn't even stay abreast of inflation. Even more detrimentally, it proposes a reduction in excess of $100 million.

This, coupled with ever-increasing demand being placed on the VA system by the aging veteran population, can only result in a reduction and decline in the quality and quantity of services to the veterans.

Three million veterans today are over age 65. By the year 2000, that number will triple to 9 million. Because it is dealing with a population whose average age is increasing much faster than the general population, the VA's accommodation to this impact could serve as a proving ground for private sector programs to follow.

Overbedding in America, which we hear so much about in the private sector is, in fact, a myth. To maintain current levels of care for the elderly of the future, the Nation's elderly will, by the year 2000, occupy all of today's empty hospital beds and require a 50-percent increase in nursing home facilities.

Today, the VA alone supports an average census of 25,000 veterans in nursing homes, 60 percent of whom are in community nursing homes. This need will double by 1995. And in contrast, OMB's budget guidance contains the words "shrink the VA system size gradually."

The VA has an exemplary record in cost containment. There's been no growth in terms of inflation-corrected constant dollars in its annual medical care budget for the last 10 years.

During this decade of straight line budgeting, there was, however, a marked increase in productivity and economy. The average length of patient stay was reduced by one-third. The total annual patient workload increased by 30 percent. Annual outpatient visits increased by 2 million. An additional 3,723 nursing home beds and 16 outpatient clinics were added to the system, and 136 new Vet Centers provided readjustment counseling to over 300,000 Vietnam-era veterans.

During the same period, 16,000 VA hospital beds were closed.

It's a remarkable track record.

There has to be a point at which you can no longer continue to do more with less.

Of critical concern to PVA are the staffing levels proposed by the Department of Medicine and Surgery and the simultaneous treatment of that staff.

The proposed budget not only denies the need for increased staffing to meet the rising demand, but in an illusion of smoke and mirrors that would do credit to Houdini, also carries over current inadequacies by freezing DM&S employment levels at fiscal year 1985 levels.

There's been a lot of talk here about 2,000 FTEE below. In fact, that number is closer to 4,000 below.

By disregarding the clear, congressionally intended staffing levels for fiscal year 1985 by over 2,000 FTEE, which is carried over into the 1986 budget and the failure to provide the VA with a 2,000-plus FTEE needed to staff newly constructed facilities, the proposed budget results in the Department of Medicine and Surgery being 4,000 employees below the number needed.

The construction budget of $611.6 million in new budget authority indicates that the administration is not recognizing the importance of maintaining and building adequate facilities if the VA is to perform its assigned functions.

One year ago, the Chief Medical Director testified on behalf of the 1985 budget and stated at that time, in defense of the construction budget for 1985, that over 53 percent of all VA patients were in hospital beds in buildings more than 30 years old.

If we follow OMB guidance and only replace hospitals at the rate of two a year, those hospitals, which are presently 30 years old, will be 70 years old and more before we get around to them.

One last thing and I will conclude—and that's to comment on the proposed consolidation of the Department of Veterans' Benefits.

We did a little look at it—first of all, we challenged the $25 million up front. It's a ridiculous number, and I don't know how anybody could have come up with it, when you consider it costs $35,000 to $40,000 to relocate an employee, the cost of buying and leasing buildings, breaking leases, packing, shipping, relocation of files and equipment, installation costs of telephones and everything else.

But we looked at one other thing. This departs a little bit from the testimony we've submitted for the record, because we have some new facts in. We examined 33 of the 58 VA regional offices and found out that they had 6,039,711 veterans' files in those offices.

By extrapolating from that, we come up that the total VA regional office activity has 10,615,000 veterans' files. These are located in five-drawer file cabinets; each file cabinet holds 200 files.

By dividing the number of active files, which is about 183,000 per regional office, by five-drawer file cabinets at 200 file each, we come up with the fact that the VA would need 53,076 file cabinets. These cabinets are 1.25 linear feet wide, coming to a total of 66,345 linear feet, or a national total of 12½ miles of cabinets.

Thus, each of the three consolidated offices will have an average of over 4 miles of cabinets. In terms of area, these cabinets require 5.2 square feet each, including a 25-inch aisle, for a total of almost 276,000 square feet for all cabinets, and 92,000 square feet of space for the cabinets alone in each consolidated office.

Add to this the square footage of all requirements for cross aisles, working space for all employees and their necessary equipment and adjunct facilities, the sheer immensity and volume of folders of each consolidated office, conservatively computed, is at least 3.5 million files each, further presents the question of the time factors which must be considered for obtaining any given file.

We could go on, longer than that, but I think we've proven the ridiculousness of that concept already.

Chairman MURKOWSKI. You didn't mention anything about data processing in here, did you?

Mr. POWELL. Data processing has no such set miles.

We do have a recommendation, Mr. Chairman, at the end of our testimony, where we suggest that the committee require of the Administrator, prior to the submission of the next Presidential budget, a complete plan for the automation of the Veterans' Administration, all departments and all functions, so that the committee will have that information when it next chooses to sit down and consider the budget.

Last, but not least——

Chairman MURKOWSKI. What did they tell you the last time you asked them to do that?

Mr. POWELL [continuing]. Well, we understand that, with a meeting that we had yesterday in the Administrator's office, that the VA has, in fact, embarked upon such a program with a timetable that was indicated to us would be concluded about September 1985. We believe the Administrator's intention.

Chairman MURKOWSKI. Well, that's progress, I guess.

Mr. POWELL. Thank you.

Chairman MURKOWSKI. Do you have anything further, Mr. Powell?

Mr. POWELL. No, sir. I think I've said enough.

[The prepared statement of R. Jack Powell, executive director, Paralyzed Veterans of America, follows:]

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

PREPARED STATEMENT OF

R. JACK POWELL, EXECUTIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE

THE SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING THE

PROPOSED FISCAL YEAR 1986 VETERANS ADMINISTRATION BUDGET

FEBRUARY 20, 1985

Mr. Chairman and Members of the Committee, it is a privilege for me to speak here today on behalf of the members of Paralyzed Veterans of America.

Initially, I want to take this opportunity to officially welcome you, Senator Murkowski, as the new Chairman of this Committee. PVA looks forward to working with you, the other Members and the fine staff of the Committee on Veterans' Affairs as we address the needs of our nation's veterans and their dependents. And, we would be remiss if we did not comment on the fact that while Senator Simpson had to relinquish the chairmanship of the Committee we are pleased to see he remains a very valued Member.

I sincerely appreciate this opportunity for PVA to address its views and concerns regarding the Administration's proposed Fiscal Year 1986 VA Budget.

PVA recognizes the need to reduce the federal deficit, but in examining the proposed Fiscal Year 1986 VA Budget, we find the targeting of veterans' health care and services as a source of spending cuts and deficit reduction to be a reprehensible approach and a disservice to the men and women who have served the nation.

Historically, this country has cared for its veterans. This huge task cannot be left to state and local governments which are not equipped for such an effort, and are already overburdened. The cost for providing for our nation's veterans is an obligation that is associated with the continuing cost of our national defense.

Mr. Chairman, this year, the nation's 28 million veterans, and their 53 million dependents and survivors will have to rely upon the wisdom and energies of this Committee, and Congress as a whole, to secure adequate funding for the programs and services administered by the VA. Repeatedly, the Congress has had to struggle to add funding to proposed budgets that were patently insufficient to meet the needs of the nation's veterans, and the task this year will certainly be as challenging as any we have witnessed during the past several years.

The Administration's proposed budget falls short of meeting the current needs of veterans and fails to adequately address future needs. The proposed budget authority of $27.1 billion is a decrease of $123.5 million from the current, fiscal year 1985, level. And, the proposed budget fails to provide for the needed growth of facilities and services that was so clearly projected only twelve months ago. Last year before this Committee we were able to state:

> "The proposed 1985 budget authority of $27.2 billion, if accepted by Congress, will generally preclude the diminution of VA programs. And, the proposal in certain instances, such as funding for medical care and construction of nursing homes, represents a real attempt to improve existing VA services and redress past neglect."

It is obvious that the Administration's commitment to providing adequately for the nation's veterans has been short lived. The proposed Fiscal Year 1986 budget not only reduces the progress achieved in the last year, it portends even greater damage to veterans' programs and services in future years. This year's budget proposal does not even stay abreast of inflation and even more detrimentally it proposes a reduction in excess of $100 million. This, coupled with the ever increasing demand being placed on the VA system by the aging veteran population can only result in the reduction and decline in the quality and quantity of services to veterans.

During the course of our examination of the Administration's proposed Fiscal Year 1986 Veterans Administration budget it has become clearly evident that economic concerns have far outweighed moral obligations. The proposed budget fails to address veterans needs, now and in the future, and indicates a trend of abrogating what has historically been the nation's responsibility toward the men and women who have served in its defense.

The Administration, through its FY'86 budget proposal, makes quite clear its imperviousness to any understanding of the medical needs of the aging American, let alone the aging veteran. The coming impact of the aging veteran had been a responsibility which the Veterans Administration was taking very seriously. After more than a year of demographic analysis, discussion and review by outside consultants, it published in mid-1984 a comprehensive report "Caring for the Aging Veteran." The veracity of this report was further supported by a Lou Harris survey and contracted studies by Harvard University's Division of Health Policy Research and Education. A simultaneous report from the Congressional Budget Office concurred with the data obtained from the VA's demographic survey.

The VA plan provided a detailed overview, based on projected need, of the opportunities presented by the aging of its constituents. Where as three million veterans today are over age 65, by the year 2000 that number will triple to nine million or 36 percent of all veterans. Because it is dealing with a population whose average age is increasing much faster than that of the general population, the VA's accommodation to this impact could serve as a proving ground for private sector programs to follow.

To maintain current levels of care the nation's elderly will, by the year 2000, occupy all of today's empty hospital beds and require a fifty percent increase in present nursing home facilities. In more dramatic terms tomorrow's elderly will require the opening of one hundred nursing home beds every day for the next fifteen years. Today the VA alone supports an average census of twenty five thousand veterans in nursing homes, sixty percent of whom are in community nursing homes. This need will double by 1995.

The main emphasis in expanding VA geriatric capability, however, was to be placed on non-institutional care programs such as outreach satellite clinics, adult day care centers and rehabilitation units, hospital based home care and hospices. The VA had intended to seek legislation in this area for increased sharing and coordination with the private sector. The goal was to exert maximum effort to integrate VA programs for the elderly with similar programs in the community at large.

In spite of these well documented requirements no program enhancement resources appear in the proposed coming year budget or in its out year projections. In contrast, OMB budget guidance contains the words "shrink the VA system size gradually." Blocking the development of geriatric program alternatives to institutionalized care will have a stultifying effect on the VA's system, and will itself add to overall costs and, in turn, drastically retard the nation's preparedness to meet the medical and socioeconomic needs of its aging citizens.

FY'86 budget cuts affecting the private sector are also of significance to veterans because of the impact upon the VA health care-system. During the past few years Congress has reduced projected Medicare/Medicaid expenditures by some 18 billion dollars. The President has proposed additional cuts from Medicare and Medicaid of $5.9 billion in FY'86 and $27.1 billion by FY'88. Included are reductions in Medicare reimbursement for capital expenditures; a fifty percent reduction in Medicare indirect subsidy for medical residency education and severe cuts in federal support for medical education loans and scholarships.

The fact and future of the VA and the private sector medical systems are inextricably linked. One third of all veterans over the age of sixty-five are said to be medically indigent, which may explain why the VA medical system is proving to be a demonstrable safety net for veterans who can no longer afford the increased co-payments of Medicare. In 1983 some 800,000 of the three million veterans over age sixty-five came to the VA for one form of care or another. That represents over twenty-five percent of all veterans in that age group. And one half of them had never previously made use of the VA health care system.

FY'86 budget decrements for the VA Department of Medicine and Surgery are, in many ways, reflective of options under continued study by the White House Office of Policy and Planning. These options have been identified in the recent Congressional Budget Office report on "VA Health: Planning for Future Years," the notoriously flawed Grace Commission Report, and by the Office of Management and Budget itself.

It is unlikely that the VA health care system could be dismantled by fiat, but there is clear and present danger that full implementation of certain of these options would be tantamount to its destruction. Unfortunately, the purpose, the nature and the value of the system as a national resource is little known and even less understood by the public. Only with such understanding can the impact of certain policy proposals targeting veterans medical care be measured.

The VA Department of Medicine and Surgery is the nation's largest integrated comprehensive system. It is the only system providing a full continuum of health care to veterans made eligible for care on the basis of laws passed by Congress and signed by the President. From its research laboratories have come tremendous contributions to medical knowledge. The VA is also the nation's single largest health manpower production resource and, as a key element in national security, the principal on-line contingency backup to military medicine. It is a system clearly worth saving. It is, in fact, a model for the nation, a harbinger of things to come. Its integrated, comprehensive provision of service is a blue-print for the vertical and horizontal integration now underway in the private sector's effort to adjust to the competitive medical market.

Up front should be an appreciation that the VA has an exemplary record in cost containment. There has been no growth in terms of inflation corrected constant dollars in its annual medical care budget for the past ten years. During this time the annual inflation rate for the Medical Care Price Index averaged twelve percent while the yearly VA medical operating costs increased by seven percent. The FY'75 VA medical care budget figure was $3.7 billion and in FY'85 $3.6 billion in constant 1975 dollars.

During this decade of straight line budgeting there was, however, a marked increase in productivity and economy. The average length of patient stay was reduced by one-third and the total annual patient work load increased by thirty percent. Annual out patient visits increased by two million. An additional 3,723 nursing home beds and sixteen out patient clinics were added to the system and 136 new Vet Centers provided readjustment counseling to over 300,000 Vietnam Era veterans. During the same period sixteen thousand VA hospital beds were closed.

In light of the progress made in the VA health-care system in terms of efficiency and the increasing demand being placed upon it, it is most disturbing to PVA that the Fiscal Year 1986 budget proposal contains provisions which can only be detrimental to the VA and the veterans it serves. The proposed funding for medical care is decreased in constant dollars and the proposed medical construction budget is reduced substantially from the current level. Specifically, the reduction in FTEE's and the proposed five percent pay reduction will have deleterious effects on veterans. In addition the cost saving initiatives contained in the budget proposal are questionable at best.

Of critical concern to PVA are the staffing levels proposed for the Department of Medicine and Surgery and the simultaneous treatment of that staff. The proposed budget not only denies the need for increased staffing to meet the rising demand but also carries over current inadequacies by "freezing" DM&S employment levels at Fiscal Year 1985 levels.

During Fiscal Year 1986 the VA is scheduled to activate, or open a number of facilities, such as new nursing home care units, outpatient clinics, renovated hospital wings, and outpatient clinic additions, which will require over 2,000 new employees to staff these facilities. The proposed VA budget fails to make funding available to meet these increased staffing requirements. Instead, the budget presumes that productivity increases will offset the need for this increased staffing.

By disregarding the clear, congressionally intended staffing levels for Fiscal Year 1985, by over 2,000 FTEE's (which is carried over into the 1986 budget), and the failure to provide the VA with the 2000-plus FTEE's needed to staff newly constructed facilities, the proposed budget results in the Department of Medicine and Surgery being 4000-plus employees below the number needed. It goes without saying that it makes no allowance whatever for the inevitable escalation in demand for services associated with the increasing number of older veterans who are now eligible for and requesting health care from the Veterans Administration.

PVA is also very concerned over the wisdom of the Administration asking all government workers (including VA employees) to submit to a 5 percent pay cut this October 1. It is within the purview of "Uncle Sam," as an employer to request this of his workers, but the request must be questioned especially if increased productivity, good employee morale, and retention of a good labor force is desired.

Based upon an independent study which was just completed and transmitted to the House Committee on Post Office and Civil Service on December 4, 1984, (Hay/Huggins study) today's Federal worker is already underpaid. In fact, if comparing cash compensation only, the study shows that General Schedule (GS) worker's pay would have to be increased by 10.3 percent just to match private sector pay levels for equivalent positions, and the differential for a given GS position range from 2 percent, at the lower GS grades to 25 percent in the upper grade levels.

Given the benefit of Federal civil service retirement system part of this difference is lost. Still when comparing total compensation paid (wages, health and disability benefits, retirement, vacation, etc.) the Federal employee lags behind his private sector counterpart an average of 7.2 percent. Taking into account the changes being proposed for the Federal worker's retirement program and this 5 percent pay cut, the differential between Federal and non-Federal work compensation will become even more exacerbated.

The question must be asked, "Can we afford the long-term consequences that this 5 percent pay cut can have on the efficiency and productivity of the Federal work force."

PVA is adamantly opposed to any such pay reduction because we know firsthand the devastating effect it portends for a system that is already understaffed, especially as it exists in many spinal cord injury units and rehabilitation facilities. The ability to attract, to train, and to maintain qualified personnel to carry out the Federal responsibilities mandated by Congress is largely dependent upon that employer being equitable both in the treatment of their employees and the rate of compensation paid them.

The VA's FY'86 proposed construction budget of $611.6 million in new budget authority indicates that the Administration is not recognizing the importance of maintaining and building adequate facilities, if the VA is to perform its assigned functions. This is particularly true regarding the emphasis on the construction of new nursing home facilities.

It had been previously determined that just to replace the system's antiquated hospitals and maintain its plant facilities at the current size would require a one billion dollar (in constant 1985 dollars) construction budget for the next ten years. Implication of intended future policy is also to be found in the FY'86 guidance that construction projects in the out year should be sized solely upon service-connected demographic need. This is consistent with the Administration's limitation of nursing home construction to two 120 bed facilities in FY'86, a reduction of 720 beds from the level requested.

The needs of the aging veteran population will continue to place ever-growing demands on the VA's health-care delivery system, and it is extremely important that adequate physical facilities be developed and maintained to meet this demand.

Mr. Chairman, the construction proposal is not a positive sign, and it raises several questions. The failure to construct needed VA medical and health-care facilities has been one of the most troublesome veterans' issues for quite some time: by "construction" PVA means both the building of needed new facilities and the maintaining of existing ones. It is a very serious matter that so many VA facilities are now in a state of decay, after a grateful nation has provided them. Some are only marginally meeting the needs of the veterans who use them. Decaying facilities not only hamper patient usage of some VA medical facilities, but their poor condition makes it doubly difficult to recruit and retain qualified staff.

Mr. Chairman, PVA must also question the cost savings initiatives contained in the Fiscal Year 1986 budget proposal. The implementation of a "means test" assumes that veteran demand can be reduced and the establishment of third party reimbursement is anticipated to produce $65 million in savings.

We are skeptical not only of the projected savings but doubt that such programs will mitigate the growing demand being placed on the VA health-care system.

First, PVA does not oppose a "means test" per se. The institution of any "means test," however, must be equitable, being applied to all non service-connected veterans regardless of age and it must address factors other than gross household income. Significant factors such as the totality of a veteran's health-care needs must be considered in making eligibility determinations rather than relying on a single episode determination. Additionally, the factor of geographic differentials in living costs must be incorporated into any "means test". The establishment of criteria for determining what is household income poses a significant problem.

Most important, the use of a preliminary medical evaluation should not be used as the controlling factor in determining a veteran's health-care needs and ability to pay. A complete, comprehensive diagnosis, post-admittance if necessary, and a thorough consideration of future medical requirements must be incorporated into any determination of ability to pay. If an admitted, diagnosed veteran is then deemed to be able to defray costs, a mechanism for recoupment of diagnostic expenses should be considered whether third party reimbursement or not.

Finally, the question of cost effectiveness must be raised. The institution, nationwide, of the proposed means test implies significant administrative costs with no assurances that the VA will realize savings. If the means test were to winnow out certain veterans with the ability to pay, others currently being denied care would only be admitted to the system. While such a result is a positive aspect of the proposed means test, it can in no way be viewed as a means of reducing costs or demands on the system. Additionally, any use of a preliminary evaluation will address only individual episodes of health-care need and fail to consider the veteran's more extensive spectrum of medical requirements.

The proposal to effect cost savings of $65 million during fiscal year 1986 through the establishment of third party reimbursement is specious at best. Non service-connected veterans utilizing the VA health-care system do so today because they lack the resources to secure private health care. These veterans, for the most part, have no private health-care coverage. In the cases of those veterans who do have private coverage most extant policies contain exclusionary provisions which preclude payment for treatment in federal facilities.

In addition, the administrative mechanism to implement third party reimbursement currently does not exist within the Veterans Administration. The projected savings assumed in the budget would have to be the net result of establishing such a program and its associated costs. Additional FTEE would be required to administer such a program and a billing procedure would have to be created.

Mr. Chairman, PVA must also address the implications of this budget for the Department of Veterans Benefits. The proposed Fiscal Year 1986 Budget contains a total VA personnel reduction of 919 FTEE's, with the major portion thereof consisting of 624 in DVB alone. As of current date, DVB has not furnished a firm, detailed plan for implementation of the proposed budgetary personnel reductions. The essence of the plan is a consolidation of all adjudication, loan processing, finance, administrative and personnel functions now individually conducted in the various regional offices and centers into three regional centers located in the eastern, central, and western United States.

An appropriation of $25,000,000 is to be allocated for the cost of consolidation. We are challenging this estimate as grossly inadequate, considering costs such as what we consider to be a realistic estimate of $35,000 to $40,000 alone, as a relocation cost per individual. Our challenge is also based on consideration of costs of finding and leasing, buying or building, suitable quarters for the consolidated offices; overlapping leases and costs of breaking leases; packing, shipping and relocation of files and equipment; installation costs of telephonic and other communications equipment; direct and indirect employee costs such as severance pay, early retirement and inevitable loss of production and deterioration of employee morale as office closings and relocations become imminent. Another major factor will be the cost of procuring, installing and programming computers with adequate capacity and training operators for such equipment.

Bearing on the logistics of consolidating all active claims folders in three centralized locations, consideration will have to be given to the sheer immensity of the files storage problem. Based upon representative inventory figures obtained from what we consider an average sized Adjudication Division, we have made the following assumptions and computations. Of the approximate 105,000 C-Files in that office, 90,000 are considered active.

They are housed in filing cabinets which are fifteen inches wide and approximately twenty-five inches deep. These 5-drawer cabinets have an average of 40 files per drawer or 200 per cabinet. We have conservatively extrapolated a total of 5,220,000 active files in the United States based on multiplication of 90,000 by 58 RO's.

Dividing this total number of active files by 200 gives us a requirement of 26,100 cabinets which, taking a total of 1.25 linear feet (width) each, comes to 32,625 linear feet or a national total of six miles of cabinets or two miles of cabinets per consolidated office. In terms of area, these cabinets require 5.2 square feet each (including a 25 inch aisle) or a total of 135,720 square feet or approximately 45,000 square feet of space for the cabinets alone in each consolidated office. Add to this the square footage of the requirements for cross aisles and working space for the employees, their necessary equipment, and adjunct facilities.

The sheer immensity and volume of folders per regional office, conservatively at least 1.75 million files per office, further presents the question of the time factors which must be considered for obtaining any given file. Of much more serious consequence is the ever-present danger of a major loss of C-Files, with all of their irreplaceable military and personal records, correspondence, etc., in the case of a catastrophic fire, comparable to the disaster at St. Louis in the early seventies when many millions of irreplaceable veterans' records were destroyed. Many a veteran undoubtedly suffered a denial of his claim, solely due to the fire.

The proposed consolidation will produce both tangible and intangible consequences. From management point of view they anticipate a cost saving after the initial cost of moving and consolidating is hurdled. However, we perceive damaging costs and consequences far exceeding in scope and importance any monetary benefit gained by the consolidation. In the VA publication entitled "Budget in Brief Fiscal Year 1986", the VA includes a preamble entitled "MISSION & GOALS". The VA states that its mission includes an obligation to be the "principal advocate" of veterans and their families in ensuring that they receive the benefits they have earned in service to this Nation. Further, the VA strives to ensure that an appropriate level of benefits is provided within the law to eligible veterans and beneficiaries. We are greatly concerned that the VA will be straying far from its "mission" and that consolidation will result in and produce a major deterioration through the depersonalization of claims processing.

The removal of processing employees from the respective areas they currently serve has the inevitable consequence of divorcing them from any sense of local identity and responsibility. There will be the loss of the ongoing relationship carefully cultivated in office after office by the top management, including the Adjudication Officer and his staff as well as by the Director's office with local facilities, agencies and important officials. This local friendly relationship and knowledge of local agencies such as police officials, courthouse personnel, and local record keeping agencies often proves vital in cutting red tape and expediting processing of claims.

We perceive an immediate increase in the piecemeal assembly of data required for claims processing, with a consequent increase in the time required for effective development of claims. An immediate sequel to poorly developed and poorly adjudicated claims is a corresponding increase in the filing of appeals by dissatisfied claimants. The more the VA will have to rely on computer-generated correspondence, the less detailed and explanatory will be their letters. Consequently, the level of dissatisfaction referred to above will inevitably increase the already heavy BVA load, significantly increasing its backlog and lengthening appeals processing time.

A major loss to the entire veterans' community throughout this Nation will be the deprivation of an availability of a local office at which a veteran or other claimant could appear for a personal hearing. Long experience tells us that a hearing is most effective when conducted before the very people who will be making the decision. Even if the VA were to provide alternative methods of conducting hearings by a separate hearing body in local areas, we submit that with the claims folders located in only three areas, the final decision will most probably be made by rating personnel who have had no contact or feel for the individual in question.

But the greatest concern we have relates to the impact any consolidation would have on the existing role of National Service Officers, of this organization and of all others, now located in every regional office, where they are geared to providing personal one-on-one service with claimants. In turn, these service officers have all developed effective working relationships with their respective VA Adjudication personnel. Both the VA and the claimants have thus benefitted from this relationship. We cannot perceive how such an effective one-on-one relationship can be replaced or duplicated at the three consolidated offices. The quality, effectiveness, and timeliness of all services to claimants, promised so openly by the VA, can only deteriorate under the proposed plan.

In essence, the service organization representatives will be neutralized without local access to the VA C-files. With no case development at a local level, the time to process these claims will double, if not triple, because of the time factor involved to collect pertinent information.

The 1986 budget will indeed cause a severe hardship as far as staffing problems, cost of relocation and forced restructuring of the service organization's work force in the field. Service organizations would be forced to beef up their development staff in the consolidated regional offices and, therefore, would be faced with the costs related to relocating their own personnel. Furthermore, the relocations made would cause a serious reduction of the work force which would otherwise be available to staff the remaining service organization contact offices in the field.

Also taking into consideration the relocation, as well as the loss in work force, we feel it imperative that the VA consider the loss of the free assistance afforded them by the veterans' service organizations. For example, the combined veterans' organizations last year alone handled approximately 35% of all claims filed and 40,000 personal hearings, both formal and informal. Relative to the hearing processes, the veterans may be subjected to traveling great distances and be expected to defer the expense of their travel and lodging out of their own pockets, if they desire to expedite their claims and not wait for the travelling board. Furthermore, there will be the more severely disabled veterans with the same desires who would be deprived of this right because of their physical inabilities to travel the great distances which could be involved. In any case, the loss of one on one personal contact with the veteran and his representative will be limited, if not totally destroyed, in untold thousands of cases.

Taking into account the ramifications of this budget's effect on the service organizations, also raises questions as to the VA's ability to handle the projected workload, when considering the consolidation and resultant reduction in personnel to include the assistance afforded by service organization representatives. There will be an overall impact on a number of the smaller organizations due to their limited availability of funds that must be considered. They would not, in fact, be able to afford to defray the expense of transferring service officers into the three designated regional offices and, therefore, the ability to represent their clientele would be severely hampered if not actually obviated.

The extended claims processing time is a priority issue as viewed by the service organizations. It is our opinion that we could safely project a 50 percent increase in the time involved to process a claim from the date filed to the date the veteran is notified of the decision. This extended processing time will add to the severe hardship which is placed upon those veterans awaiting a decision from the Veterans Administration and who are indeed in desperate need of this assistance. We further anticipate the sheer volume of the caseload anticipated and resulting confusion of a consolidated operation can be expected to increase, and cause disruptions of the flow of vital information necessary to prosecute pending claims. In view of the present economic state, literally thousands of veterans are being forced to turn to the VA for assistance for the first time in their lives. If one also takes into account the present age of the World War II veterans as well as the Korean veterans and the increase of Vietnam veterans now seeking benefits from the Veterans Administration, we find it difficult to accept the VA's projections of a reduced workload in the upcoming years.

In summary, indications are that the proposed DVB budget cut was made arbitrarily, and the proposed consolidation of regional offices into three locations was made in desperation, on orders to cut costs, rather than by plan. As a result, there is no evidence of a firm plan for the targeted reduction of FTEE projected during the next three years, or in fact, even where the cuts are to be made. Additionally, the tentative locations of the consolidated claims centers have not been identified, or feasibility studies conducted.

Taking into consideration our conservative estimated space requirements for each site, it is difficult to visualize how the VA can realistically select a site, without making a detailed space requirement analysis, and then secure an adequate sized building in the selected location (if one exists) before the proposed FTEE reductions are actually made. Obviously, if the proposed reductions become fact before the preliminary plans and related arrangements are completed, the actual damage to the ability of the VA to process claims accurately and in a timely manner cannot be estimated. We may experience chaos in the system that will take many years to rectify, not only in regard to the disrupted administrative procedures, but more importantly, the irrevocable damage done to the well being of the needy veteran dependent on VA benefits services for survival.

Another issue of concern to the members of PVA is a proposal within the VA's "Home Loan Guaranty" program. This is an entitlement program, with every veteran meeting the requirements, as provided by statute, being eligible for the guaranty of their mortgage. Since its inception in June 1944, the VA Home Loan Guaranty Program has assisted over 11 million veterans and their families in gaining suitable, affordable housing.

The Guaranty can be made up to 60 percent of the loan or $27,500, whichever is less. In the event of default, the [illegible] will pay to the lender the outstanding balance due on the loan plus costs incurred through foreclosure, up to the amount of the guaranty. In most cases arrangements have been made for the lender to convey the property to the VA, in order to encourage lender participation in the VA Home Loan Guaranty Program, to minimize administrative costs, and, most importantly, to retain flexibility to allow a deserving veteran in the family home even after mortgage default.

Now this year, the Administration is proposing legislation to increase funding fees on VA guaranteed loans from one percent to five percent. Veterans who use their VA Guaranty entitlement, and purchasers of VA owned property would either have to pay the five percent fee up front, or pay a one percent fee while making a minimal down payment of five percent, or have the five percent added into the loan, thereby raising the actual amount borrowed, coupled with having Private Mortgage Insurance added to the monthly mortgage payment.

Putting this added cost into the VA Home Loan Guaranty program would all but insure the demise of the program and of veterans being able to use their VA entitlement in obtaining affordable housing.

The average cost today of a VA guaranteed home is $60,000. By adding the new five percent funding fee, veterans would require at least $3,000 cash just to be eligible to use their VA guarantee for housing.

One of the most valuable benefits in the VA Home Loan Guaranty Program has been the feature of no money down. A veteran may now buy a home with no down payment, providing his or her income is sufficient to support payments; the VA's home loan program is the only home lending program that carries this feature.

Another aspect of the housing proposals is to repeal the current authority to establish maximum interest rates and allow for borrower/lender negotiated rates. Currently, under Title 38 the Administrator has the authority to set maximum allowable interest rates. The FHA in 1983 repealed their interest rate policy similar to the VA's current policy, choosing instead to go to a negotiable rate.

Introduced in the 99th Congress, as H.R. 1 (Section 533), is legislation that appeals the current authority by FHA, and reverts back to current policy being used by the VA. This alone should be an indication that the proposed method of negotiable rates by borrower/lender does not work. PVA opposes the proposal of raising the user fee from one percent to five percent and repealing the authority for setting the percent rates. We believe that the current VA Home Loan Guaranty program has and continues to serve veterans well, giving the veteran borrower the opportunity to secure a low cost loan, with no down payment, thereby fulfilling the American dream of owning a home.

And finally, Mr. Chairman, ending on a positive note, the proposed Fiscal Year 1986 VA Budget contains a 4.1 percent increase in the rates of veterans receiving disability compensation, Dependency and Indemnity Compensation, and nonservice-connected veterans and widows in receipt of pension, effective January 1, 1986. PVA welcomes this proposal because we continue to believe that veterans and their survivors must not be subjected to the erosive effects of inflation.

It must be noted, however, that there continues to be consideration given by certain members of the Administration and others to the possibility of taxing compensation and other veterans' benefits. PVA finds such suggestions abhorrent. Compensation is provided to veterans for injuries or conditions sustained in or aggravated by service to the nation. It is unconscionable to give legitimacy to any of these proposals.

In closing, Mr. Chairman, it is PVA's belief that there are areas within the Veterans Administration which, if properly addressed, can be made more cost effective and efficient. It is recommended that this Committee, and Congress as a whole, require the Agency to submit a comprehensive Automated Data Processing (ADP) initiative to the Congress prior to the submission of the Fiscal Year 1987 budget. The VA's ADP system is plagued with problems and current, piecemeal efforts offer no prospect for successful resolution. The present method of requiring $1.10 reduction in FTEE expenditures for every

$1.00 spent in ADP acquisition is an impractical and illusory effort to effect savings and enhance productivity.

Similarly, PVA recommends that the VA be tasked with providing a report to Congress before the next budget submission that establishes a bed sizing model which addresses the future needs of all veterans. This model must be applied consistently for new construction, as well as, conversion or closure of existing facilities. The reliance on the use of DRG's is inappropriate for such a model due to their newness and their failure to cover a significant number of conditions or multiple conditions being treated by the VA today.

Mr. Chairman, PVA is aware that this is a time of challenge. We recognize that it is incumbent upon all of us to insure that the taxpayers' money is expended in the most equitable and efficacious manner possible.

PVA believes it is a time of challenge for the Congress to provide leadership. We understand you face the adversity of limited resources. But remember, that the benefits and programs we are addressing today were earned in adversity. Integrity, honesty and constancy of both individuals and nations are, and always have been, tested in times of adversity, not times of plenty and of ease. The problems confronting us are a challenge to all of us and yet it is essential that we pass the test.

Mr. Chairman, and members of the Committee, I again thank you for the privilege of appearing today. I have discussed numerous concerns within the proposed FY86 VA's budget, but I hope I have lent some insightfulness here today. This concludes my statement, and I will be glad to answer any questions that I can.

Chairman **MURKOWSKI**. Mr. Bobby Muller.

Mr. Muller is president of the Vietnam Veterans of America, and he is accompanied by Mr. Dennis Rhoades.

I welcome you and look forward to your testimony.

Mr. **MULLER**. Thank you, Mr. Chairman.

Like everyone else, we'd like to congratulate you on your leadership role and wish you the best of luck——

Chairman **MURKOWSKI**. Thank you.

Mr. **MULLER** [continuing]. In what you do.

Chairman **MURKOWSKI**. I appreciate your good wishes.

Mr. **MULLER**. We are heartened and appreciative of what you said at the beginning of the session today, in two particular respects: First, in your noting that there are still needs for Vietnam veterans that have got to be specifically addressed. And second—which is what I want to address in my statement summary today—the need to do something, which we have a unique opportunity right now to do, which is have a serious total reevaluation of what we're doing in this country in the area of veterans' affairs.

We could argue on specific administration recommendations for budget reductions, given our sensitivities as Vietnam veterans and our experiences.

But frankly, we don't have the scope of expertise, the resources, or the access to information to do the proper job in assessing the future of a $27 billion a year agency. What are the cuts to make?

Frankly, when we started as an organization in 1978, we asked a very simple question: What does the country owe its veteran population? Is not $27 billion enough money to meet that basic need?

We were directed to President Eisenhower's 1955 Commission on Veterans' Benefits which was chaired by Gen. Omar Bradley. Certainly nobody would argue that either General Eisenhower or General Bradley were not soldiers of distinction who had tremendous sympathy, empathy, and compassion for veterans.

And yet, the recommendations of the Bradley Commission were basically set aside by some of the veterans' organizations in this country and by the Congress and by respective administrations, because, in straightforward language, what the Bradley Commission said was found to be politically unacceptable.

Perhaps we have President Reagan to thank for bringing us all to the point where finally we have the opportunity for everyone to agree that the time has come, like it or not, to look at what we're doing and take on those issues that before we may have considered too tough to examine.

The way to go about this is to set up an objective commission that will be assured that its recommendations are not going to be simply set aside. They have got to develop a coherent philosophy or rationale, as a guide to the development of veterans' benefits.

The commission should review what's happened since the Bradley Commission recommendations were made, in terms of other social welfare programs in this country, and how that affects the distribution of veterans' benefits to the veteran population.

The commission should examine what's happening with the military today and the levels of compensation that servicemen are being paid, compared to what they were being paid years ago.

What does a competitive wage mean in terms of active duty benefits that we should have under the guise of veterans' benefits?

A lot has happened. $27 billion, in our view, is more than enough to meet the basic legitimate needs of the veteran community.

You can no longer have the representatives of the organizations come before this committee and say, "Because we're patriots, because we served, you can't take away anything that you've given us over the years."

Look at what's happened in other sectors in this country, and start to regard yourself perhaps more as an American, on equal footing with all the other people in this country, and not a privileged class of citizenry simply because you did that which was your obligation to do, which was serve when the country called.

So, Mr. Chairman, in closing, I just want to stress we urge a very strong commitment to an objective, bipartisan commission that will reevaluate all aspects of veterans' benefits entitlement and the philosophy behind it. Thank you.

Chairman MURKOWSKI. Thank you very much, Mr. Muller, for that very pointed recommendation.

[The prepared statement of Robert O. Muller, president, Vietnam Veterans of America, follows:]

PREPARED STATEMENT OF ROBERT O. MULLER, PRESIDENT, VIETNAM VETERANS OF AMERICA

Mr. Chairman, Vietnam Veterans of America (VVA) appreciates the opportunity to appear before this Committee to relate our views on the Administration's proposed fiscal year 1986 budget, as it affects veterans programs and services. We view this year as a particularly important year in veterans affairs, one in which decisions will be made which will profoundly affect veterans benefits for a generation. We appreciate the extraordinary efforts going on in this Congress to manage an unacceptable federal budget deficit. VVA is not so much concerned with actual dollars which may be trimmed from veterans programs, as much as we are in the process of determining from which areas those funds are to be taken. VVA does not believe that the veterans services system which has evolved over the past forty years ought to be changed piecemeal or subject to the ephemeral whims of ideology or politics. We are well aware that the VA's programs have been studied and restudied over the years, but the veterans benefits system has never been evaluated *in toto* since the Bradley Commission under President Eisenhower undertook its review some thirty years ago. Since that time we have had two GI Bills, new pension programs, major changes in employment programs, as well as the evolution on a broad, national scale of human services and health care programs. A review of the entire benefits and services system would allow all of us-the Executive Branch, the Congress, and the veterans service organizations--to see, for the first time in three decades what the needs of our veterans really are. It will allow an evaluation of how well existing resources are meeting those needs, which programs may be antiquated or wasteful, and how the use of limited federal dollars may be optimized. VVA is currently developing a proposal for such a review mechanism which we will outline when we present our legislative agenda to this Committee on February 27, 1985.

The Administration's proposed budget which we are considering today does not, in our opinion, rationally and realistically consider the needs of veterans. Such needs we believe have been and should continue to be a high national priority. That much having been said, we must also note that on several major issues, we have been pleasantly surprised. We are pleased to note, for example, that a cost of living allowance freeze has not been imposed upon compensation and pension. An OMB budget paper which VVA obtained in December had originally proposed such a freeze on a number of programs, including compensation and pension. VVA does not in principle oppose such freezes, as long as they are fair and applied across the board to all income transfer programs. Since this is evidently not to be the case, we are pleased to see that the proposal was dropped, and a 4.1% increase authorized.

VVA is also pleased to note that the OMB recommendation to eliminate all National Programs under the Job Training Partnership Act (JTPA) has been dropped and that these programs including Title IVC, the National Veterans Job Training Program, will continue. We are disturbed however, over a cut of some $2 million for title IVC in 1986. It is our view that this program has been grossly underfunded, and is a vital tool to assisting non-job ready Vietnam veterans. VVA will be discussing this issue with the appropriate Congressional Committees in the coming months.

As we have indicated, we are encouraged by these apparent shifts in the Administration's policy toward veterans programs. We are not, however, in agreement with a number of other proposals contained in the budget.

VVA is very concerned over the future of the VA health care system, not so much by what is being proposed in the Administration's budget, but by what is left unsaid or unresolved. VVA wishes to make it very clear that we do not and cannot support any proposal which would deny a veteran health care who genuinely needs the VA. The proposed income test, by setting an upper eligibility level of approximately $15,000 is too low for VVA to support, particularly if that includes a spend-down provision under which the veteran would be forced to divest himself of all assets over $15,000.

In addition, apparently left unaddressed is how the proposed income test might affect veterans who have applied to a VA hospital for Agent Orange or PTSD related problems. It seems to us that the VA health care system in particular would benefit from a review and clarification of its mission and goals. An attempt to bring changes to a system such as this where the only objective is to save money, could be very damaging to the complex VA medical program.

A similar lack of objective analysis seems to attend the Administration's proposed consolidation of the Department of Veterans Benefits. VVA has long believed that DVB needs major structural changes, primarly to bring the Department closer to the veteran client and to create a closer network of veteran services at the community level. The proposed consolidation would do just the opposite by centralizing and isolating the adjudication process and leaving a skeletal staff which, in most locations, would be the only DVB office in the state. We find the proposal particularly objectionable in that it would centralize both the Rating Boards and elements of the Loan Guarantee Division. We are aware that the Administration is suggesting the creation of traveling rating boards, but VVA believes that there is no way these Boards could even approximate adequate service for veterans entitled to and requesting hearings. As this Committee is well aware, the Board of Veterans Appeals has had problems associated with traveling panels for years. VVA believes that consolidation will greatly increase delays associated with the adjudication of benefits. We are also frankly mistrustful and believe the time will come in the near future when the VA will return to this Committee asking for partial or complete elimination of the Regional Offices. Such depersonalization of the agency is clearly antithetical to the best interest of the veteran whom the Agency exists to serve.

Mr. Chairman, in regard to the VA Home Loan Mortgage Guaranty

Program, we urge you to secure passage of the full $404 million needed to maintain the revolving fund. This program has functioned well for forty years in its basic purpose of enabling the veteran of moderate means to purchase his or her first home. We believe that this was the primary intent of the act and the Congress has reaffirmed this intent many times since. VVA strongly believes that an origination fee of no more than 1% must be maintained in order to preserve the central thrust of this program. VVA will recommend in hearings next month before this body, that a number of changes be made in the program that will generate more funds to help keep this program stable, while preserving its original central intent. These recommendations include a 5% origination fee for "resorted usage" participants, 5% fee on non veteran users of VA-vendor financing, and a modification in accounting so that all proceeds for the sale of acquired properties go back into the revolving fund. This last recommendation addresses a key point, Mr. Chairman, which is that the Loan Guarantee Revolving Fund is still experiencing losses due to foreclosure and acquisition costs as a result of the aftermath of the 1982-83 recession and concomitant major economic dislocation. This recommendation would halt the "hemmoraging" of the revolving fund, to a large degree.

Mr. Chairman, Vietnam Veterans of America also calls upon you to do your utmost to preserve the U.S. Small Business Administration as an independent agency with a continuing strong program for veterans. In FY '84, the SBA assisted over 5,000 veteran owned businesses with long term financing, totalling almost $700 million dollars. This was almost 25% of all direct and guaranteed loans by the SBA. Perhaps even more importantly, Mr. Chairman, over 100,000 veterans received management assistance and training under the auspices of SBA, a great number of whom received such vital skill training as a result of the special veteran outreach program as SBA.

This is not a "cost" to the government, rather, it is an investment. SBA have added $468 billion to the GNP and returned $142 billion to the U.S. Treasury in taxes. VVA urges you to ensure that SBA is continued as an independent agency with an augmented management assistance and training staff and, at least, level funding of the $1.68 million in veterans outreach and training program funds for FY '86. Under the leadership of Jim Sanders and Marshall Parker SBA has made great strides toward being responsive to the needs and aspirations of veteran enterpreners. VVA asks for your leadership in preserving this investment in America's future.

Mr. Chairman, that concludes our remarks. I would be happy to answer any questions you or the Committee may have.

Chairman **Murkowski**. I reference the reality that, much like the discussion that's going on in this country over our defense budget, we can never have, obviously, enough, because we don't know something that is that intangible. While the obligation of this country is to those who have served it, you can never do enough to repay that obligation. As a consequence, we are here today reflecting on the individual points of view of the various members of the committee and those that are responsible for providing that service and those of you who represent the servicemen and women in this country who are recipients.

I would, first of all, say that I think your suggestion on an objective review through an appropriate structure—such as you've suggested, an objective commission—certainly seems to have an appropriate position in the sense that it has been a long time since there has been an evaluation of the services.

We have heard from witnesses today who make reference—and rightly so—to their concern over the reduction in services.

But as I've stated earlier, at some point in time we will come to a position where we have so much in the pot, and the question is do we make it available in the same old way, or do we try and streamline or look for new implementation of ideas and procedures?

It would be interesting for this committee to reflect back. I don't know very much about the Bradley Commission.

You've stated, Mr. Muller, that it was basically put under the rug because it was too hot to handle politically. And that may be.

Is this a timely point to consider bringing that out and seeing, just from the cursory standpoint of an outline, what its recommendations were, and then look at the appropriateness of putting together a commission set up by—and I'm not about to say whom, but at least address those with the appropriate input and knowledge and see where we're going. Because, if it's been 30 years, why that's a long time.

The needs change and the services change. The thing that doesn't change is the continued commitment to fund it.

I would be most willing to look forward to your input and that of the other members and representatives here today to pursue this idea.

I will request Mr. Principi and the professional staff to pull out the Bradley Commission report, to do, from our point of view, an outline—and I don't mean 120 close typewritten pages. I'm talking about a review that the layman can read and understand and you don't have to turn to your attorneys to write you an opinion on it—as to what it said—not the editorializing of what it might do—and come back again and discuss this further and see if it does have merit.

It would be interesting to see whether there is a reaction initially similar to the reaction when the Bradley Commission was proposed, because if there is, that obviously will tell us something, too.

I very much appreciate your testimony, all of you, and your suggestions.

I do not think we have any other questions. Obviously, we're going to be seeing much more of each other as I have an opportunity to participate in the learning process.

I want to thank all of you for being here.

Those of you who sat through the entire testimony, I want to thank the staff from the majority and the minority, and you, Tony.

And we wish you a very good day.

Until we meet again, thank you.

[Whereupon, at 4:40 p.m., the hearing was adjourned.]

[The prepared statements of Donald L. Custis, M.D., former Chief Medical Director of the Veterans' Administration, and Frank S. Sato, Inspector General of the Veterans' Administration, and the Inspector General's responses to written and followup questions submitted by Hon. Frank H. Murkowski, chairman of the Senate Committee on Veterans' Affairs, follow:]

PREPARED
STATEMENT OF
DONALD L. CUSTIS, M.D.
PRESENTED TO
THE SENATE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING THE
PROPOSED FISCAL YEAR 1986 VETERANS ADMINISTRATION
DEPARTMENT OF MEDICINE AND SURGERY BUDGET
FEBRUARY 20, 1985

Good morning Mr. Chairman, I am Donald L. Custis, M.D., and I had the pleasure to serve as the Chief Medical Director of the Veterans Administration from January 1980 until May 1984. I appreciate this opportunity to comment on the proposed Fiscal Year 1986 Budget for the V.A.'s Department of Medicine and Surgery. As always, it is a pleasure for me to testify before the Senate Committee on Veterans' Affairs and address our mutually shared concerns for the health care of the nation's veterans.

The FY 86 budget for the V.A. Department of Medicine and Surgery in gross figures gives the misleading impression that resources are being frozen at essentially current services level. However, a line item study of that budget together with references to multiple statements printed in various OMB budget guidance papers, gives cause for concern. Disturbing also is the use of inaccurate data, misleading statements, and even aspersions upon the V.A. health care system.

To name a few examples:

Excerpt: "The VA projects that (due to the impact of the aging veteran) maintenance of the status quo policy will result in annual medical care and construction requirements as high as $37 billion by the year 2000."

Fact: The VA in its publication "Caring for the Aging Veteran" estimated this cost at something between $18 and $22 billion, the net increase in which would be largely offset by expected reduction in compensation and pension funding.

Excerpt: "89 percent of all veterans have private health insurance coverage."

Fact: Various surveys have shown this figure to be not less than 36 percent and not more than 51 percent.

Excerpt: "Virtually all of these over 65 veterans, like the rest of the elderly population, will be fully covered by medicare."

Fact: They are not now and will be even less so in the future.

Excerpt: "Despite repeated assertions, elimination of exclusionary (insurance policy) clauses will not lead to abandonment by veterans of the VA system -- known as "mainstreaming."

Fact: Entitlement for third party reimbursement has absolutely nothing to do with "mainstreaming".

Excerpt: "The 1986 resources will support the 'aging vet.'"

Stated elsewhere: "Funding caps provide no guarantee that resources necessary to provide care to disabled and poor veterans will be available".

Excerpt: "Despite the fact that VA draws heavily on low-cost intern and resident services, the average patient treated by the VA costs the taxpayer more than the comparable Medicare patient treated in the private sector."

Facts: This statement is categorically not true. (Parenthetically the internship was done away with several years ago. The FY 86 budget cut funding for resident physicians by $14,340,000.)

Excerpt: "In 1983, only 10.8 percent of VA health care was delivered to the service-connected (SC) population."

Fact: At any given time approximately one third of all in-patients and one half of all out-patients are service connected.

Excerpt: "Outlays for medical care and facility construction have grown at 12 percent average annual rate producing a 5 fold increase since 1970."

Fact: What is not said is that in constant, inflation corrected, dollars, there was straight line budgeting between 1975 and 1985. During that decade all growth was due to increased productivity and cost containment. To quote the VA Administrator "The VA continues to lag behind annual inflation increases significantly. This rate of growth has not resulted in deserved recognition of our Nation's veterans."

The proposed FY 86 budget shows, in several instances, disdain for Congressional mandates and prerogatives. Most blatant perhaps is the recent arbitrary cut in 1985 medical care employment of 2,092 FTE from the 193,941 FTE which Congress ordered. Carrying this reduced 1985 personnel level into FY 86, an additional denial was made of 2,068 FTE to staff eleven new nursing homes and other clinical facility activations. The VA identified a need of 2,594 FTE for these activations, but the request was cut by over 500 and direction given to absorb the balance. And then a further decrement of 1,916 FTE was exacted for pay reduction and an expectation of increased productivity. In actuality there will be 6,076 employees below the number needed to make it a "current services" budget, but figures are so juggled as to claim a new increase of 199 FTE over the 1985 Medical Care employment. In spite of this, increased workloads are set for both in-patient and out-patient care.

Similarly ignored is the Congressional mandated bed level of 90,000 - to include hospital and nursing home beds only. Budget documents now include domiciliary beds to this tabulation. In FY 86 2,761 hospital beds are to be closed and 1,847 additional nursing home beds opened by conversion (204) or new construction (1,643). The combined hospital/nursing home bed level falls from 89,570 to 88,656.

A two percent increment of $181 million is allowed for inflation, but that will be partially nullified by an inability to achieve all of the savings from management reduction programs for which $271 million was decremented -- programs such as A76 and 3rd party reimbursement.

There are two such management initiatives introduced in this budget and incorrectly labeled cost saving programs, namely, a means test to look behind the poverty oath, and the legislative proposal for third party reimbursement. I personally have strong reservations about each and define those concerns in an article I am submitting as an attachment to this statement. Briefly, I believe the unmet patient demand on the VA system is so great that any means test will not in itself accomplish any workload reduction. A means test could be a valuable management tool however, if it were designed to be flexible, equitable and practical. Third party reimbursement is also not really a cost savings provision but rather a way to shift costs from the taxpayer to the insurance premium payer.

Cuts in MAMOE funding are much more critical than they appear. Employment reduction in DM&S Central Office may be twice the figure given of a 78 FTE, because of lack of sufficient personnel services dollars.

In the above references attachment comment is made regarding FY 86 restraints on construction and the impacts of other cuts. I would, however, like to observe that the OMB policy of exacting $1.10 in FTE resources for every one dollar expended on ADP procurement flies in the face of private sector experience. It is nevertheless an effective way of forestalling innovation and productivity gains.

My chief concern, however, has to do with what the projected outyear numbers portend for the future integrity of the VA health care system. Policy is clearly being made through the budget process and OMB's announced intent is to eliminate another 8,000 health care employees by 1990, provide no resource enhancement in anticipation of the impact of the aging veteran and only permit new construction based on "service-connected demographic justification".

Mr. Chairman I do appreciate the economic situation and the difficult job facing the Congress of dealing with the budget deficit. If, however, the VA health care system is to be squeezed there are ways to do so without threatening its integrity or compromising its quality. I refer to vertical cuts instead of continued horizontal leveling. There are hospitals that could be closed and others which should be entirely converted to nursing homes. There are cost efficient alternative programs to institutionalize care which should be permitted to expand.

If we have really come to the issue of its survival certainly this system is a national resource worth saving. There are multiple arbitrary line item caps in this FY 86 budget which are very destructive. The Department of Medicine and Surgery is in the hands of extremely talented people who should be given the management flexibility for the most judicious use of restrained resources.

THE CHALLENGE TO THE V.A. HEALTH CARE SYSTEM
PORTENTS OF THE FY'86 MEDICAL CARE BUDGET

Donald L. Custis, M.D.

A new dimension was applied this year to the FY'86 Federal Budget process. Under a strategy called "front loading", recommendations of the Office of Management and Budget for drastic cuts in domestic programs were presented to the President and leaks provided to the press prior to the usual return of budget proposals to the respective Federal Agencies for their final review and rebuttal. Especially noted was the President's personal involvement in line-item decision making, thus altering his traditional role as a detached final arbiter between agency heads and OMB. The technique was undoubtedly designed to arouse public interest at the earliest possible stage of budget development. No response was more vocal than the protests from those who truly understand the devastating impact of further cuts in Federal health care programs. Their concern, however, is currently without popular support. The public is preoccupied with rising health care costs, but generally lacks understanding of the causes. Unfortunately, the emphasis in public discussion of this extremely complex issue has shifted totally from the recognition that as a nation we have been successful in building the world's best health care system, which provides access to quality health care to all sectors of our population, to one that focuses exclusively on the cost factor. More ominous still is the tendency to ignore the fact that such medical care elements as human concern, compassion, and social responsibility simply do not translate into economic values.

The media, speculating on the Administration's intent, identified likely cuts in excess of what finally surfaced in the President's 1986 budget. Perhaps the press abetted a ploy of threatening the loss of a whole loaf in order to cut it in half. Given Congress' budget prerogatives, it will be months before final decisions are known. Even then the debate regarding the restructuring of the nation's health care programs will continue. Even previous discarded policy issues may be expected to resurface in subsequent budget cycles. The Administration has already proposed additional cuts for FY'87 and FY'88. FY'86 budget cuts affecting the private sector are also of significance to veterans because of the impact upon the VA health care system. During the past few years Congress has reduced projected Medicare/Medicaid expenditures by some 18 billion dollars. The President has proposed additional cuts from Medicare and Medicaid of $5.9 billion in FY'86 and $27.1 billion by FY'88. Included are reductions in Medicare reimbursement for capital expenditures; a fifty percent reduction in Medicare indirect subsidy for medical residency education and severe cuts in federal support for medical education loans and scholarships.

The fate and future of the V.A. and the private sector medical systems are inextricably linked. One third of all veterans over the age of sixty-five are said to be medically indigent, which may explain why the V.A. medical system is proving to be a demonstrable safety net for veterans who can no longer afford the increased co-payments of Medicare. In 1983 some 800,000 of the three million veterans over age sixty-five came to the V.A. for one form of care or another. That represents over twenty-five percent of all veterans in that age group. And one half of them had never previously made use of the V.A. health care system.

FY'86 budget decrements for the V.A. Department of Medicine and Surgery are, in many ways, reflective of options under continued study by the White House Office of Policy and Planning. These options have been identified in the recent Congressional Budget Office report on "V.A. Health: Planning for Future Years", the notoriously flawed Grace Commission Report, and by the Office of Management and Budget itself.

It is unlikely that the V.A. health care system could be dismantled by fiat, but there is clear and present danger that full implementation of certain of these options would be tantamount to its destruction. Unfortunately, the purpose, the nature and the value of the system as a national resource is little known and even less understood by the public. Only with such understanding can the impact of certain policy proposals targeting veterans medical care be measured.

The V.A. Department of Medicine and Surgery is the nation's largest integrated comprehensive system. It is the only system providing a full continuum of health care to veterans made eligible for care on the basis of laws passed by Congress and signed by the President. From its research laboratories have come tremendous contributions to medical knowledge. The V.A. is also the nation's single largest health manpower production resource and, as a key element in national security, the principal on-line contingency backup to military medicine. It is a system clearly worth saving. It is, in fact, a model for the nation, a harbinger of things to come. Its integrated, comprehensive provision of service is a blue-print for the vertical and horizontal integration now underway in the private sector's effort to adjust to the competitive medical market.

Up front should be an appreciation that the V.A. has an exemplary record in cost containment. There has been no growth in terms of inflation corrected constant dollars in its annual medical care budget for the past ten years. During this time the annual inflation rate for the Medical Care Price Index averaged twelve percent while the yearly V.A. medical operating costs increased by seven percent. The FY'75 V.A. medical care budget figure was $3.7 billion and in FY'85 $3.6 billion-in constant 1975 dollars. During this decade of straight line budgeting there was, however, a marked increase in productivity and economy. The average length of patient stay was reduced by one-third and the total annual patient work load increased by thirty percent. Annual out patient visits increased by two million. An additional 3,723 nursing home beds and sixteen out patient clinics were added to the system and 136 new Veteran Centers provided readjustment counseling to over 300,000 Vietnam veterans. During the same period sixteen thousand V.A. hospital beds were closed.

A series of national-level policy issues and "choices" is aswirl around the V.A. health care system, some driven undoubtedly by budget prerogatives and agendas, but others by larger philosophies or even fear and greed. All are intertwined, as is the V.A. medical care with American medicine. Depicted here are the issues most critical for future vitality of the V.A. system. Further evolution and resolution of these issues will occur as the debate heats on future directions for V.A. health care delivery.

Issue number 1: Eliminate acute care services in the V.A. health care system.

None of the options under consideration for altering the modalities for veterans medical care would have more devastating consequences than the recommendation to discontinue, entirely, acute care services within the V.A. system. In this option, as described by the Congressional Budget Office, "the V.A. would continue to assist poor veterans and those with service-connected disabilities in obtaining medical care for acute illness in private hospitals on a contract, a fee-for-service basis or through a reimbursement mechanism as yet undefined.

Without the case mix represented in current V.A. patients, the quality and continuity of care within the V.A. health care system would rapidly decline, and the system, thus limited to long-term chronic care, would revert to a chain of "Old Soldiers Homes". V.A. hospitals would have little value as a teaching base for health professionals or the pursuit of clinical research. Medical school affiliations would be cancelled and the major incentive lost for V.A. recruitment and retention of high quality medical staffs.

The ability of the V.A. health care system to serve as a backup to military medicine would also be eliminated.

Many veterans would lose medical care since much V.A. specialized care is not universally or readily available in communities. This is especially true for amputees and the functionally disabled with their continuing need for prosthetic and orthotic management. The V.A.'s provision of sustaining care for the spinal cord injured has no counterpart in the private sector.

Similarly, the professional insight and therapeutic management of the psychoneuroses of war are largely a V.A. accomplishment. The V.A. psychiatric case load simply could not be absorbed in community facilities. The existing state mental health systems are notably ill equipped to handle more patients. Too many psychiatric patients have already been discharged onto the streets of our cities without adequate support systems.

This option does not represent cost savings, it only shifts costs. In fact, the aggregate cost to the V.A. for service-connected veterans' acute care could materially increase were this option approved. The V.A.'s cost comparison studies indicate that acute care in the private sector is less economical than in the V.A. Additionally, the two-thirds of all service-connected veterans now using private hospitals could start billing the V.A. for reimbursement. The medically indigent non service-connected veterans would be a heavy extra load on the already stressed Medicare/Medicaid program with the safety net of the V.A. system no longer available to them.

Issue Number 2: Limiting V.A. health care eligibility to only the service disabled and veterans in receipt of pensions.

This option carries consequences not unlike those described above. Although the patient case mix in the V.A. medical facilities would not be so drastically changed, even the Congressional Budget Office concedes that it might make DM&S too small to be viable, particularly with regard to its academic affiliations.

This action would cut the V.A. patient census in half and necessitate the closing of dozens of V.A. hospitals. The capacity to backup the Department of Defense likewise would be materially reduced. It is the non service-connected veteran who accounts for the great bulk of indigence in the V.A. system patient census. When a mandated "means test" was last applied, a data analysis revealed that over 98% of the non service-connected patients were indeed in the poverty class. Under this option many of these veterans would be Medicaid candidates who would heavily impact the county and municipal charity bed resources.

Currently one-half of all V.A. health care system outpatients and two-thirds of all inpatients are veterans with non service-connected disabilities. They have, historically, been given entitlements to V.A. hospital care on a space, or resource, available basis and, for the past decade or more, access to ambulatory care for the purpose of avoiding hospitalization. The elimination of this case load would compromise the maintenance of the staff expertise for quality care of the service connected. Arbitrarily drawing the line on entitlement between service-connected veterans and non service-connected is morally untenable. While the V.A.'s primary charge is to care for those veterans whose disabilities were incurred during military service it has always strived not to abandon those whose subsequent disabilities have rendered them unable to care for themselves. This is, at the least, social equity, applicable to veteran and non veteran alike, and exemplifies that what we as Americans believe is one source of our national strength; we care for those who cannot care for themselves.

Issue Number 3: Vouchering.

Vouchering has been under consideration for some time by certain health care economists as a modality for Medicare resource distribution and for what is euphemistically called "mainstreaming" of veterans' medical care. While a vouchering option could have varied designs and provisions, the model most often referenced for consideration in Medicare and by V.A. mainstreaming proponents is a voluntary capitation system wherein the enrollee would be given a set price voucher to use at his or her discretion to purchase health insurance or health care in the private sector. Although the call for mainstreaming of veterans' care has thus far gone unheeded, the threat remains because of its appeal in some segments of the private medical sector. While Medicare vouchering may be a feasible option, mainstreaming could spell disaster for the continued integrity of the V.A. medical system.

At the present time the Department of Medicine and Surgery spends ten percent of its medical care budget for purchase of private medical care and services, generally, in geographic areas where there is no V.A. medical facility presence. With open ended vouchering, however, it is likely that most acute care would be siphoned from the V.A. system with an end result identical to a mandated discontinuance of V.A. acute care capability as discussed previously. Space available V.A. medical care for the non-service disabled veteran presumably would disappear and it is problematic whether vouchering would be authorized for them. As noted in issue number one costs for service-connected care would increase since those service-connected veterans not currently using the V.A. system would likely take advantage of such universal subsidy.

Once there is established such an alternative as mainstreaming, the V.A. health care system, which has served the veteran and the nation so well, would be slowly undermined until its continued existence would be doubtful.

Issue Number 4: Restraints on construction and maintenance.

The proposed FY'86 budget not only would freeze V.A. medical care at the FY'85 level, but also reduce the construction budget by more than fifty percent of projected need, funding only certain projects with outlays already committed.

It had been previously determined that just to replace the system's antiquated hospitals and maintain its plant facilities at the current size would require a one billion dollar (in constant '85 dollars) construction budget for the next ten years. The proposed FY'87 and FY'88 figures continue to ignore that reality. Implication of intended future policy is also to be found in the FY'86 guidance that construction projects in the out year should be sized solely upon service-connected demographic need. This is consistent with the Administration's limitation of nursing home construction to two 120 bed facilities in FY'86, a reduction of 720 beds from the level requested. It also serves as an introduction to the following issues:

Issue Number 5: The impact of the aging veteran.

The Administration, through its FY'86 budget proposal, makes quite clear its imperviousness to any understanding of the medical needs of the aging American, let alone the aging veteran.

The coming impact of the aging veteran had been a responsibility which the Veterans Administration was taking very seriously. After more than a year of demographic analysis, discussion and review by outside consultants, it published in mid 1984 a comprehensive report "Caring for the Aging Veteran". The veracity of this report was further supported by a Lou Harris survey and contracted studies by Harvard University's Division of Health Policy Research and Education. A simultaneous report from the Congressional Budget Office concurred with the data obtained from the V.A.'s demographic survey.

The V.A. plan provided a detailed overview, based on projected need, of the opportunities presented by the aging of its constituents. Where as three million veterans today are over age 65, by the year 2000 that number will triple to nine million or 36 percent of all veterans. Because it is dealing with a population whose average age is increasing much faster than that of the general population, the V.A.'s accommodation to this impact could serve as a proving ground for private sector programs to follow.

To maintain current levels of care the nation's elderly will by the year 2000, occupy all of the today's empty hospital beds and require a fifty percent increase in present nursing home facilities. In more dramatic terms tomorrow's elderly will require the opening of one hundred nursing home beds every day for the next fifteen years. Today the V.A. alone supports an average census of twenty five thousand veterans in nursing homes, sixty percent of whom are in community nursing homes. This need will double by 1995.

The main emphasis in expanding V.A. geriatric capability, however, was to be placed on non-institutional care programs such as outreach satellite clinics, adult day care centers and rehabilitation units, hospital based home care and hospices. The V.A. had intended to seek legislation in this area for increased sharing and coordination with the private sector. The goal was to exert maximum effort to integrate V.A. programs for the elderly with similar programs in the community at large.

In spite of these well documented requirements no program enhancement resources appear in the proposed coming year budget or in its out year projections. In contrast, OMB budget guidance contains the words "shrink the V.A. system size gradually." Blocking the development of geriatric program alternatives to institutionalized care will have a stultifying effect on the V.A.s system, and will itself add to overall costs and, in turn, drastically retard the nation's preparedness to meet the medical and socioeconomic needs of its aging citizens.

Issue Number 6: Eliminate V.A. budget support of health professional education.

The White House Working Group on Health Policy and Economics has directed the Veterans Administration to identify the dollar savings by severing all medical training from patient care resources. This concept has already been applied incrementally by OMB in its proposed FY'86 Medicare budget, by cutting in half the dollars supporting post graduate education of physicians. The VA's education and training fund is also to be cut 10% below current services.

This is a concept in defiance of the basic premise that medical education, medical research and patient care are absolutely integral to one another. Unlike most professions, the teaching of the science and art of medicine can not be confined to lecture halls. The making of a physician occurs at the patient's bedside. In the process, medical care is simultaneously delivered and is generally conceded to be the most economical and the highest quality of care. A study of this issue is currently being pursued under contract by the Department of Health and Human Services.

In the post World War II years, the designers of the modern V.A. health care system built its foundation on an extensive affiliation with medical schools. Today, 104 medical schools are affiliated with 130 V.A. hospitals. One-third of all graduate medical students in the U.S. receive some part of their speciality training in V.A. hospitals. Considering all health care disciplines there are, at any given time, 100,000 students — physicians, nurses, psychologists, lab technicians, etc. -- in training within the V.A. network. The great bulk of this health manpower output accrues to the private sector.

Medical residents alone make up almost fifty percent of the full time equivalents devoted to V.A. physician employment. The average medical resident stipend is one-third that of a V.A. staff physician. The total expenditure for all education and training is four percent of the total Department of Medicine and Surgery medical care budget. If affiliations were eliminated this year, it would take approximately 180 million additional dollars to replace the V.A. resident physician staff with full time medical staff. In fact, lacking the ability to pay high salaries, locate physicians in non-urban areas, deny opportunity for teaching and research, or offer other incentives, it would be impossible for the V.A., without medical school assistance, to recruit many of the specialists it requires for patient care. Conversely the schools would be hard pressed to support many of their faculty.

That the nation's medical schools need V.A. affiliations is an understatement of significant order. Owen Wangensteen, nationally renowned surgeon and medical educator, once said that the three greatest contributions to the advancement of American medicine during his career were the Flexnor report (resulting in medical school reformation in 1913), the creation of the National Institutes of Health and the V.A./medical school affiliation program.

Coupled with the loss of affiliations and the teaching mission would come the abandonment of DM&S research. Here again, the public is generally uninformed of V.A. research contributions to medical knowledge. A short list of those achievements include: the chemotherapy of tuberculosis and modern treatment of hypertension; the first cardiac pacemaker and the invention of the nuclear powered pacemaker; the discovery of cancer causing viruses; the robotic limb; the smart wheelchair; the self-suspending prosthetic suction socket; the invention of kidney dialysis; the first kidney transplant; the first liver transplant; the technique of radioimmunoassay; the basic concept of computerized axial tomography and the list goes on.

Budget analysts, in their designs on V.A. medical education and research, need be reminded of the adage concerning the baby and its bath water.

Issue Number 7: Cost reduction myths.

Two issues under the heading of cost savings surfaced in the FY'86 presidential budget process also raise concern. While presenting no threat to the continued integrity of the V.A. health care system these issues, as cost saving tools, are, at best, canards.

One is a means test recently intended to be implemented early this year and purported to save 400 million dollars by FY'88. A workable means test has, historically, been difficult to design. The V.A.'s latest version has recently been returned by OMB for further study and design.

A means test for use in the V.A. could be a valuable management tool were it made to be flexible, equitable and appropriately applied. Its use has already been approved by Congress in PL 96-330. But that legislation did not mandate a universally applied means test. It merely authorized the V.A. Administrator to design and make use of a means test according to his discretion in order to check, when indicated, an the validity of a veteran patient's use of the poverty oath. The report accompanying this legislation from the House Committee an Veterans' Affairs also specified: "The determination of providing care to this category of veterans is necessarily a subjective one, entailing consideration of not only the ability privately to pay for the expenses of an illness or injury, but also a judgement of whether or not the disability can be expected to require such a period of lengthy hospitalization as can be reasonably expected to exhaust the veteran's private resources."

The means test which was almost implemented was discriminatory and flawed in several respects.

It was to have been applied prospectively, at the point of entry into the system, to all non service-connected veterans except ex-prisioners of war, those over the age of sixty-five and those in receipt of pension. A preliminary and cursory medical evaluation would have provided the basis for determining the cost of private care and the veteran's ability to pay for the current episode of illness.

In contrast to what had been intended, a rational and equitable means test could be very useful were it to include the following features:

It should not be prospectively applied at the time of admission, based upon preliminary medical evaluation, but only after admission and the completion of a definitive diagnostic work up. Treatment costs should also consider the probabilities of protracted illness, and the ongoing or recurrent need for medical care, in making "ability to pay" determinations for these veterans.

It should be equitable as to age and geographic location. Special entitlement for the over 65 non service connected patient who is able to pay for private care may have once served a purpose, but under today's Medicare circumstances it has become discriminatory. If the V.A. health care system is to continue to meet the medical demands of service-connected veterans and non service-connected veterans truly unable to defray expenses, any means test must be applied equitably to every one in the latter group. Similarly, it must contain the flexibility to accommodate geographic differentials.

Living costs vary dramatically from region to region within the nation. A veteran residing in New York or San Francisco may have significantly less disposable income, even with a higher gross household income, than a veteran living in a rural area.

Finally there should be incorporated in any means test program an appellate process. Regulations covering application for all other V.A. benefits provide such recourse.

Means test screening of applicants for V.A. medical care should not be promoted as a cost saving tool, for no real savings can be predicted due to the inherent administrative costs and speculative estimates of reduced veteran demand. Since the V.A. is now turning away twenty thousand veterans every month for lack of adequate budget resources, for every applicant denied care through means testing there will be several more waiting to take his or her place.

Equally illusory is the cost saving repeatedly expected from a proposed expansion of third party reimbursement authority. The V.A. already has the authority to collect reimbursement for certain non service-disabled veteran patients who are eligible for worker's compensation or from insurance companies whose policies do not forbid such payments. Such third party reimbursement could justifiably be extended to recoup retrospectively the cost of VA furnished diagnostic procedures once a non service-connected veteran was found able to bear the cost of referral to the private medical sector.

Beyond that, however, the espousal of universal third party reimbursement to the V.A. has no rational conceptual basis except to shift the cost of medical care within the VA system from the taxpayer to the at-large insurance premium payer. All health insurance holders, including those under Medicare, will assume that extra burden. The revision of health insurance contracts will be slow and difficult and will entail added administrative costs both to insurance companies and to the V.A.

Parenthetically, data from a V.A. survey in cooperation with the Bureau of the Census showed that 64 percent of patients receiving care in VA hospitals have no health insurance at all, 16 percent qualify for Medicare and only 15 percent have some private health insurance. In contrast 90 percent of all of society have some form and degree of health insurance.

Returning to the commonality of concern regarding the program impacts of budget cuts on the private, public and veteran health care systems, one pervasive underlying frustration is dominant. This Administration, as well as Congress who gave us DRGs, PROs, PPOs and the other ingredients of the competitive medical model, have shown little interest in tackling the problem of uncompensated care, poor quality of care or the total denial of care to the indigent, the aged and the disabled. Jack Owen, Senior Vice President of the American Hospital Association, has aptly stated: "Someone has got to pay for those who can't. There is no such thing as free medical care. If we can't find a way to care for our country's poor, our health care system is a failure." The ethical underpinnings of a civilized society's social conscience and responsibility deserve more than rhetorical allusions, especially at this time when the era of the longevity revolution is upon us.

The size and demands of the nation's aging phenomenon are not easily grasped, but the implications as detailed in the medical and socioeconomic literature surely deserve more than total neglect in the design of health care policy. How long will society tolerate the narrow-minded opinion that the coming impact of an aged citizenry is but a further aggravation in medical economics which can only be solved by the rationing of medical care?

Oliver Wendell Holmes once said that the strength and security of a nation can be measured by its domestic humanitarianism. Eli Ginzberg, writing in a recent issue of the New England Journal of Medicine, voiced the deepening concern about the growing conflict between medical ethics and the monetization of medical care.

If the current neglect of ethical and humanitarian imperatives in health care legislation is to be reversed, corrective intervention will require more circumspect political leadership backed by professional and informed societal demand. Veterans can and must be a potent segment of such a consortium.

This is no time to "shrink the V.A. health care system"!

PREPARED STATEMENT OF FRANK S. SATO, INSPECTOR GENERAL OF THE VETERANS' ADMINISTRATION

Mr. Chairman, and members of the Committee, I am pleased to appear before you today to discuss the FY 1986 Budget requirements for the VA Office of Inspector General.

An average employment of 380 and $18,209,000 in budget authority is requested to support the Office of Inspector General in 1986. This request represents a reduction from 1985 levels of 9 in average employment and $1,089,000 in budget authority, of which $565,000 is related to the 5 percent pay cut.

I believe that the current funding level for my office is the minimum necessary to maintain our required level of audit and investigative activities. We fully expect to maintain this level in 1986, with less budget authority and average employment, by improving staff productivity and further refinement in our operations.

In 1986, we plan to continue to focus available resources on priority areas which would help improve services to veterans and their beneficiaries; assist managers of Agency programs and operations in economically accomplishing program goals; and prevent and deter recurring and potential errors, fraud, and inefficiencies in Agency operations. More specifically, in the Department of Medicine and Surgery we will be initiating a series of audits which are intended to address the credentials and experience of VA medical personnel and the delivery of patient care in VA medical centers. In addition to reviewing this major area of program performance, we will continue our cycle review of individual medical centers to assess and report the adequacy of facility operations.

In the Department of Veterans Benefits, we will be evaluating the effectiveness of compensation and pension eligibility decisions and the overall efficiency of Departmental and Regional Office operations. We will continue our application of computer matching techniques to compare compensation and pension data with state wage reports. We are receiving excellent cooperation from the States in our computer matching program. A majority of the States have indicated a willingness to provide their state wage reporting files for our use in assessing the accuracy of beneficiary reported data.

Our investigative unit will be directing a significant portion of their time and efforts towards the detection and prevention of fraud by various third party providers involved in the VA's programs. An example of these investigations would be the Home Loan Guaranty program for mobile homes.

My office has made great strides in the use of microcomputers to collect, sort and analyze data pertinent to ongoing audits and investigations. These microcomputers are completely portable, and permit use of modern technology as another dimension to our audit and investigative capability. This ADP capability has the potential for improving productivity by reducing the turn-around time previously associated with the coordinating retrieval of the required information from the Data Processing Centers, or relying on hardcopy sources and by opening new areas for analysis previously not physically possible.

We are coupling this enhanced ADP capability with the development and implementation of two specialized guides for auditing VA Medical Centers and Regional Offices. These two guides, which have special ADP applications, will permit better and more in-depth audits of all VA facilities; more precise identification of program weaknesses; and as a result, lead to further potential cost efficiencies. The Office of Inspector General believes it can continue to make a significant contribution to the efficiency, effectiveness and integrity of Agency programs, and we will continue to work closely with Agency managers to improve Veterans Administration operations.

Mr. Chairman, this concludes my prepared statement. I would be happy to respond to any questions which you or other members of the Committee might have.

RESPONSE OF FRANK S. SATO, INSPECTOR GENERAL OF THE VETERANS' ADMINISTRATION TO WRITTEN QUESTIONS SUBMITTED BY HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 1A. It appears that the Office of Inspector General (OIG) has been understaffed and underfunded over the past few years. However, the Administration's FY 1986 budget requests approximately $1 million less than the FY 1985 budget and reduces FTEE by 9.

Please explain the reason for the reduction of the requested funding and FTEE levels for the OIG for FY 1986 compared to the FY 1985 levels.

Answer 1A. $565,000 of the $1,089,000 reduction from FY 1985 funding levels represents the effect on personal services of the Administration's Legislative proposal (effective January 1, 1986) to reduce employee pay by 5 percent. The remaining $524,000 and reduction of 9 FTEE represents the Office of Inspector General's share of a VA-wide reduction in FY 1986 GOE funding and FTEE levels.

Another factor affecting our FY 1986 level, pertains to the impact of the FY 1985 Deficit Reduction Act on our FY 1985 approved level. The 15.2 percent reduction in travel under Section 2901 of the Act resulted in an overall OIG FY 1985 decrease of $360,000. Therefore, the full effect on our FY 1986 level, in comparison with our FY 1985 allowance, is a reduction of $1,449,000.

Question 1B. Please comment on the impact this will have on each section of the OIG's operations, particularly in view of the reduction of funding for personal services.

Answer 1B. Our present plans are to reduce the FY 1986 staff assigned to cyclical audits of medical and regional office facilities by the 9 FTEE. Staffing for the other components of the office will remain at FY 1985 levels. We believe that we can maintain FY 1985 levels of performance through productivity improvements resulting from the increased use of microcomputer technology in our audit and investigative work and through the implementation of two specialized guides for auditing VA Medical Centers and Regional Offices.

Question 2. It appears that budget constraints now, more than ever, will require increased productivity, detection of inefficiency, and cost savings throughout the entire Veterans' Administration. Is the FY 1986 budget request for the OIG sufficient to provide the necessary resources to ensure that the Office of the Inspector General can achieve this desired goal for the VA?

Answer 2. The VA approved and submitted to OMB a proposal for a FY 1986 funding level of $21,764,000 and 424 FTEE for the Office of Inspector General. At this level, the Office would be better equipped in terms of FTEE and other resources to meet the mission requirements outlined in the Inspector General Act of 1978. Specifically, with these additional resources, we planned to reduce the audit cycle of VA Regional Offices from 5 to 3 years and to provide better scope and depth of coverage to our cyclical audits of VA medical centers.

These increases were not approved and the current approved FY 1986 funding level for the Office is the absolute minimum necessary to maintain our required level of audit and investigative activities. However, even with the reduced funding and FTEE levels, we expect to at least match FY 1985 levels of performance by increased use of microcomputer technology. These microcomputers will help us expedite our audits and investigations and improve our capability to uncover fraud, waste and inefficiencies in Agency programs and activities.

Question 3. Please indicate how the OIG's resources (FTEE & funds) are allocated for audits and investigations of the Department of Medicine and Surgery (DM&S) and the Department of Veterans' Benefits? How is this allocation determined?

Answer 3. The Office of Inspector General has made a complete assessment of its workload and associated resource needs. This assessment divides the workload into the following four categories and gives the general staffing percentages for each category at a full staffing level:

- Cyclical audits of Agency facilities	(37%)
- Program and functional audits of Agency activities	(33%)
- Investigations	(17%)
- Executive management, technical support and and administration.	(13%)

Even though the Office of Inspector General is staffed at a level considerably below its full staffing level, the allocation of resources to these four categories of workload remains approximately the same at our current staffing levels.

In terms of total FY 1986 resources for the Office, 256 FTEE (67%) have been allocated to cyclical and program audits, 75 FTEE (20%) to investigations and 49 FTEE (13%) to executive management, technical support and administration.

Question 4. Please indicate what resources (FTEE and funds) were allocated to monitor the activities of the DM&S Office of Medical Inspector and Evaluation for fiscal years 1983 and 1984 and what resources will be allocated for this purpose for fiscal years 1985 and 1986.

Answer 4. The FTEE and funds allocated to the Office of Inspector General to monitor the activities of the DM&S Office of Medical Inspector and Evaluation are as follows:

FISCAL YEAR	FTEE	FUNDS
1983	1	$35,000
1984	1	37,500
1985	1.5	55,000
1986	1.5	52,000

Question 5. Please submit copies of any quality assurance standards, including those pertaining to morbidity, mortality, and the credentialling of VA physicians, which you use as part of your efforts to monitor the quality of care in DM&S medical facilities.

Answer 5. The OIG is not responsible for monitoring the quality of care in DM&S medical facilities. Any quality assurance standards for monitoring morbidity, mortality and the credentialling of VA physicians would be the responsibility of DM&S. We do perform quality assurance reviews as a part of our cyclical audits of medical facilities. In addition, we perform special purpose reviews to assess the adequacy of quality assurance in selected program areas. For instance, we are currently reviewing mortality statistics in selected diagnostic related groups between medical centers to determine the existence of unusual patterns which might indicate the need for improved medical care. Further where standards are established by DM&S, they may be used as criteria for evaluation purposes.

Question 6. What, if any, audits relating to quality assurance are ongoing or planned? Please provide a description of the purposes of the audits and the projected time frame for the completion of the audits.

Answer 6. Quality assurance is a factor of consideration in each of our cyclical audits at VA medical centers. We routinely review the status of corrective actions taken by management to implement recommendations made by the DM&S, Systematic External Review Program (SERP) and JCAH review teams. In addition to the cyclical facility audits, we periodically perform systemwide audits which touch on quality assurance issues. We currently have the following three audits in this category in process:

Audit	Purpose
VA Malpractice Claims	To review claims filed to determine if appropriate actions were taken in resolving the claims and that conditions leading to the claims have been corrected.
VA Standards of Performance	To review the DM&S performance monitoring system to determine whether appropriate actions are taken to review and correct conditions leading to any high patient mortality statistics.
VA Doctor Credentialling	To review the composition of the VA physician staff to determine the effectiveness of the processes for doctor credentialling.

All three audits are expected to be completed by July 1985.

Question 7. Mr. Walters stated in his testimony before the Senate Veterans' Affairs Committee on February 20, 1985, that he has ordered an investigation by the Inspector General into the appraisal process utilized for the Home Loan Guaranty Program. Please provide a description of the purpose, scope and status of the investigation, as well as the projected completion date.

Answer 7. Our review of property appraisal procedures under the VA Home Loan Guaranty Program will focus on the integrity of fee based appraisals prepared by independent, private sector individuals. The review will draw a sample of property appraisals from the systemwide population of loan appraisals related to failed loans experienced since Fiscal Year 1982. Audit preparation work is underway and we are planning an initial report covering preliminary findings by May 1, 1985.

RESPONSE OF THE OFFICE OF THE INSPECTOR GENERAL TO A WRITTEN FOLLOW-UP QUESTION SUBMITTED BY HON. FRANK H. MURKOWSKI, CHAIRMAN OF THE SENATE COMMITTEE ON VETERANS' AFFAIRS

Question 5.

Question 5. Please submit copies of any quality assurance standards, including those pertaining to morbidity, mortality, and the credentialling of VA physicians, which you use as part of your efforts to monitor the quality of care in DM&S medical facilities.

Answer 5.

Answer. The OIG is not responsible for monitoring the quality of care in DM&S medical facilities. Any quality assurance standards for monitoring morbidity, mortality and the credentialling of VA physicians would be the responsibility of DM&S. We do perform quality assurance reviews as a part of our cyclical audits of medical facilities. In addition, we perform special purpose reviews to assess the adequacy of quality assurance in selected program areas. For instance, we are currently reviewing mortality statistics in selected diagnostic related groups between medical centers to determine the existence of unusual patterns which might indicate the need for improved medical care. Further where standards are established by DM&S, they may be used as criteria for evaluation purposes.

[Pursuant to a verbal request for further response to written question 5, the Office of the Inspector General of the Veterans' Administration provided the following response:]

Office of Inspector General
Washington, D.C. 20420

Veterans Administration

APR 2 3 1985

In Reply Refer To:

Honorable Frank H. Murkowski
Chairman, Committee on Veterans Affairs
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

In response to your staff's request I have enclosed copies of our cyclical medical facility audit guides that pertain to our reviews of VA's quality assurance programs. While Office of Inspector General (OIG) auditors do not make medical determinations regarding the quality of care provided, we do make procedural reviews in the Department of Medicine and Surgery (DM&S).

In reference to your question 4 concerning our nationwide audit "Quality Standards for Professional Programs," we have requested information from DM&S regarding quality assurance and mortality standards; however, we have not been provided the information at this date. In the absence of standards established by DM&S, we will analyze experienced performance data between facilities for indication of out-of-line performance.

Sincerely,

Frank S Sato

FRANK S. SATO
Inspector General

Enclosure

Medical Service

(9) Since it is administratively easier to replace a piece of equipment than to acquire additional equipment, some services may seek to acquire additional equipment under the guise of replacement. The auditor should ensure that equipment is replaced with comparable items. Also, unused and "junk" equipment should be turned in to avoid having it being used for this type of replacement.

4. QUALITY ASSURANCE REVIEWS. The VA and external accrediting agencies require the continued review of professional activities to ensure the highest level of patient care. While the auditor cannot evaluate the adequacy of professional activities and judgments, it is possible to ensure that the administrative requirements of these reviews are being met and that management has established appropriate internal controls to ensure the quality of patient care.

a. POTENTIAL PROBLEMS

(1) Medical records are not being maintained in accordance with Agency and JCAH requirements.

(2) In an affiliated environment, staff physicians may not be adequately documenting the supervision of residents and students.

(3) Consultations may not be completed in a timely manner, causing increased lengths of stay.

(4) Utilization reviews may not be done or may not be effectively used to control lengths of stay or unnecessary excessive treatment.

(5) Quality assurance reviews and audits may not be done in accordance with Agency or JCAH requirements.

b. AUDIT GUIDES

(1) Obtain and become familiar with Joint Commission on Accreditation of Hospitals (JCAH) and VA standards for medical record documentation. Determine if the Medical Service is complying with these directives. Review facility and Service policies and procedures (including applicable board and committee meeting notes) and analyze the minutes for indications of problems in medical record documentation. If problems are indicated in the minutes, determine the adequacy of action taken by Medical Service to correct the problems. Determine if quantitative/qualitative reviews of medical records are performed. If deficiencies are noted during the reviews, determine if there is an effective system for followup and correction of deficiencies. Evaluate compliance with JCAH and VA requirements by reviewing a sampling of active patients' medical records in Medical Service.

(2) Obtain and become familiar with VA regulations, policies and procedures regarding supervision of residents and students. Review local policy and determine if Medical Service is complying with these directives. Evaluate Medical Service records pertaining to supervision of residents and students and determine if the degree of supervision meets VA requirements. Determine if work schedules have been established and if they are followed. Of particular importance is whether VA gets what it pays for: (1) when residents rotate out, and (2) educational detail (1/6th rule). Determine how supervision is provided during holidays, weekends and at night.

(3) Review and evaluate local policy regarding timeliness of consultations. Determine if delays in completion of consults have significantly lengthened inpatients' stay in the hospital. Select a representative sampling of recently completed consultations and determine the amount of time between the date the consultation was requested and the date it was completed. Analyze the information gathered from the sampling and determine what impact the waiting time for consultations had on patient's length of stay.

(4) Evaluate the effectiveness of Medical Service participation in the utilization review function. Determine if Medical Service participates in the facility utilization review plan to ensure review of justification for admission to the facility and if admission criteria are documented. Determine if length of stay is routinely reviewed and if criteria and norms are documented. Determine if Medical Service monitors utilization of laboratory, radiology, and nuclear medicine resources by house staff and medical students and other medical staff to ensure appropriate utilization. Determine if consultations and special diagnostic techniques are monitored for under and over-utilization and if criteria for admission to and retention in special care units (ICU, CCU, RCU, etc.) are documented and followed. Select three major deficiencies cited in utilization reviews and determine if and how corrective action was taken.

(5) Determine if Health Services Review Organization (HSRO) reviews are done in accordance with Agency policy and local policy. Review reports and committee meeting notes generated under the HSRO program. Evaluate the content of HSRO reports and committee meeting notes. Determine if findings, conclusions and recommendations result in corrective action. Select a representative sampling of HSRO recommendations and determine if appropriate action was taken to correct deficiencies.

5. PROFESSIONAL SERVICE SUBSPECIALTIES PROGRAMS/CLINICAL. Medical Service accomplishes its mission through the use of a large number of clinical subspecialties. These subspecialties may or may not be specifically identified as organizational sections of the Service. Some subspecialties may be provided as a part of

Surgical Service

a. POTENTIAL PROBLEMS

(1) Timekeeping practices may not accurately reflect duty status of employees.

(2) Equipment is idle, clinics are not staffed, patients' waiting time is increased or backlogs develop in workload because employees may be late or fail to report for scheduled duty.

(3) An adequate leave system may not have been established for residents.

b. AUDIT GUIDES

(1) Review timekeeping procedures and records used in Surgical Service. Determine who verifies accuracy of time and attendance records and how they are verified (sign in log, personal observation, telephone). Determine if procedures are effective for verifying time and attendance for all categories of employees including residents and part-time physicians.

(2) Obtain schedules of duty for residents and part-time physicians and schedules of clinics. Determine if clinics are often cancelled or start late due to staffing. Also, be alert for idle equipment or workload backlogs if time and attendance appears to be a problem. Discuss patient waiting time with MAS auditor. (Work acomplished in paragraph 2b(1) may satisfy part of this step.)

(3) Reconcile number of employees in Surgical Service with number paid. Also reconcile number of residents with number paid. Coordinate with Fiscal Service auditor.

(4) Review file of outside professional activities for remuneration. Verify that employees are not receiving dual compensation from outside professional activities, affiliated medical school or contractors (if professional service contracts are used in the Service).

5. SELF-EVALUATION, QUALITY CONTROL AND CORRECTIVE ACTION. This portion of the audit evaluates the effectiveness of administrative and quality controls in detecting problems relating to unauthorized use of, or access to resources. Appropriateness of action taken to correct problems after they have been identified is also addressed in this portion of the audit.

a. POTENTIAL PROBLEMS

(1) Unauthorized surgical procedures may be performed, such as nontherapeutic cosmetic surgery.

(2) Unauthorized patients may receive treatment at VA expense without appropriate justification. For example, non-veterans could receive inpatient, outpatient or fee-basis

treatment; and non-service connected veterans could receive treatment on a fee basis.

(3) Controlled substances in Surgical Service may not be adequately secured or may be used for unauthorized purposes.

(4) Problems previously identified through internal or external reviews may still exist.

(5) Self-evaluation and quality control procedures may not be effective in identifying problems.

b. AUDIT GUIDES

(1) Review Systematic Internal Reviews and other reports, surveys, and quality controls for at least a 1-year period. Evaluate the quality of reports and effectiveness of corrective action taken on identified problems. Include problems identified through both internal and external sources.

(2) Verify that internal or external reviews cover high risk areas. Evaluate high risk areas that have been overlooked.

(3) Determine type and amount of cosmetic surgery performed. Review judgment sample of medical records for cosmetic surgery patients.

(4) Determine who approves fee basis surgical procedures. Evaluate procedures used to assure patients are eligible for fee basis surgery if approved in Surgical Service. If approved outside of Surgical Service, coordinate with other auditor.

(5) Observe general security of resources during course of audit. Evaluate controls and security over controlled substances in Surgical Service. Coordinate with Pharmacy Service auditor.

Psychiatry Service

2. Psychiatry is not actively coordinating with other mental health or support services.

3. Psychiatry does not have established service policies or procedures.

4. Program goals are not established.

5. Program goals are not being measured to determine results.

6. Staff and resources are not being used effectively.

7. Costs of programs (inpatient and outpatient) are too expensive.

8. Day hospital and day treatment programs are not accomplishing intended results.

9. Identification of patients eligible for outplacement is ineffective, resulting in extended and high-cost periods in the hospital.

10. Coordination between physicians, nurses and social workers is inadequate to assure an effective outplacement program.

11. Alternative outplacement models utilizing local community voluntary organizations and facilities are not being considered, resulting in high-cost inpatient treatment.

More specific details are given in the audit coverage section of this guide.

IV. AUDIT OBJECTIVES

A. GENERAL. This guide's objective is to assess the efficiency, effectiveness and economy of Psychiatry Service operations.

B. SPECIFIC

1. The efficiency of Psychiatry Service operations can be measured by its interaction and relation to other mental health services as well as the degree of response from user/direct services, such as Radiology, Laboratory, Pharmacy, etc.

2. The effectiveness of the Psychiatry Service can be evaluated through average daily census, patient recovery rates, certifiable recidivism, the types of research and teaching programs available.

3. The efficiency of the Psychiatric Service operations can be judged through program costs, staffing criteria, staffing posture and equipment usage. The audit should determine if there are indications of weaknesses, vulnerabilities or impairments in Service operations which interfere with the accomplishment of the Service's mission and which warrant the dedication of audit resources to a detailed review of Service operations.

4. The audit should contain sufficient tests and examinations of Service operations as are necessary to enable the auditor to make statements of positive or negative assurance regarding individual operating segments of the Service or regarding overall Service operations.

V. AUDIT COVERAGE

A. GENERAL. One of the problems inherent in the development of any audit effort is defining the extent of coverage necessary for the auditor to reach a supportable conclusion regarding the operations of the audit entity. The auditor must rely on his experience in the audit area and his professional skills and judgment in deciding if the extent of his audit work has been sufficient to support his opinions on Service operations. The following audit guide segments provide guidance on the functions and responsibilities of the operating sections of the Psychiatry Service. These segments also identify potential problem areas and points of program or functional vulnerability to fraud, waste and abuse and inefficient or uneconomical operations. However, the auditor must rely on his judgment, imagination and experience in his evaluation of Service operations and should use these areas only as reference points from which to develop an individualized audit approach to the Service.

B. SPECIFIC

1. Inpatient. Each NP hospital shall have the basic psychiatric service to treat acute and chronic psychiatric illnesses. The Service should be able to provide prompt evaluation, treatment, continuity of treatment and disposition of a psychiatric patient.

a. Potential Problems

(1) The hospital does not have a logical progression of treatment to move patients from acute care to stabilized care, chronic care or rehabilitation.

(2) The Psychiatry Service is not communicating effectively with other mental health or support services.

(3) Radiology and Laboratory Services are not responding to Psychiatry Service needs.

(4) The Psychiatry Service or hospital does not have policies on the following:

(a) Suicide precautions/preventions.

(b) Assaultive behavior.

(c) Excessive therapeutic drug use.

(d) Use of physical restraints.

(e) Admissions and discharges.

(5) The facility is not effectively outplacing psychiatric patients to outpatient programs or the community.

(6) The Psychiatry Service is over/understaffed according to available staffing criteria.

(7) Staff is not being properly utilized.

(8) Equipment and space are not being properly utilized.

(9) Required AMIS or other management reports are not prepared.

b. AUDIT GUIDES

(1) Determine the types of inpatient psychiatric programs at the hospital.

(2) Determine if assessments are being made in triage area; are estimates of length of stay being given for patients admitted to the hospital.

(3) Are patients mentioned as to the length of stay in each program to assure patients are outplaced to other programs or to the community? Acute beds should have shorter length of stay than intermediate or chronic care beds.

(4) Are patients prioritized as to service or nonservice-connection when admission is considered? Is treatment eligibility checked?

(5) Determine if patients are being referred to other institutions, regularly. (May indicate lack of needed inpatient programs.)

(6) Are consultants being brought into the hospital on a regular basis? Is the hospital staff incapable of performing workload?

(7) Determine if Laboratory and X-Ray (Radiology) Services are responding to Psychiatry Service requests in a timely manner. Discuss this issue with its Chief of Psychiatry to determine if problem exists.

(8) Review Psychiatry Service patient turnover rate for each of the inpatient programs available. Compare this data to other comparable facilities. Be aware that the more acute the condition, the shorter the length of stay and the faster the turnover rate. If excessive length of stay is noted, determine reasons for the "bottleneck."

(9) Are patients moving out of the hospital into outpatient programs or into the community in a timely fashion. Discuss problems with Chiefs of Psychiatry and Social Work Service. It may be possible that chronic patients are just not capable of being outplaced; however, the auditor should convince himself that these patients are, in fact, incapable of outplacement rather than problems with Social Work Service.

(10) Determine if the Service has policies in the following areas:

(a) Suicide prevention.

(b) Restraint and seclusion of patients.

(c) Usage of psychotropic medications (overuse of drugs is a concern).

(d) Admission of psychiatric patients.

(e) Discharge of patients - evaluate policies.

(11) Evaluate the management of the Service. Look for weaknesses in the organizational mode; i.e., no Chief of Service (Acting Chief for long periods of time); high employee turnover; inability to recruit; lack of policy or program guides or instruction; inadequate planning for or absence of new programs; high recidivism rate in any of the inpatient programs; weaknesses in budget formulation or inability to stay within budget guidelines; complaints made by other clinical or administrative staff regarding their interaction with the Psychiatry Service; type and number of internal reviews or quality assurance. Note: Excessive untoward incidents between patients or employee/patients; high suicide rates; high/low occupancy rates in one or all of the types of programs; high medication refusal rate, etc.

(12) Determine number of resident slots in the facility. NP hospitals should, of course, be substantially filled with psychiatry residents. Determine residents' specialty. Are they being supervised?

(13) Evaluate the adequacy of staff utilization. Look for indicators of poor staffing ratios (either too high or too low), such as excessive overtime, overstaffing based on bed to professional staffing criteria, inappropriate specialties. Are employees assigned collateral duties which interfere with their primary duties. Is the supervisory ratio appropriate? During tour of the Service, note if personnel "look" busy.

(14) Evaluate the condition of the inpatient wards. Are they clean, cluttered, functionally inappropriate, etc.?

(15) Evaluate equipment utilization by obtaining the Service CMR's. Tour the Service and look for equipment not being used (i.e., dust accumulation, items stuffed in closets, etc.); for expensive equipment items, determine if staff has the knowledge to operate item--are they calibrated regularly (if applicable)?

(16) Determine if the Psychiatry Service is complying with internal control and applicable policies and procedures. For instance, are all required AMIS reports submitted timely and accurately, are drug security requirements followed, are applicable licenses current?

(17) If the facility has Psychiatric Research, assure physicians are spending the appropriate amount of time in their specialties and in their research programs.

(18) Determine the number and types of specialized programs, such as drug dependency, alcohol dependency. Does the Service have policies on the admission to these programs? Are program goals established; are they being met?

2. OUTPATIENT

a. POTENTIAL PROBLEMS

(1) Patients are not being placed into outpatient programs from inpatient treatment in a timely manner.

(2) Outpatient programs are not effectively being used to avoid hospitalization.

(3) Program goals and objectives are not being established and/or met.

(4) Staffing and program resources are not being used effectively.

(5) Required reports are not being prepared.

(6) Length of treatment policies are not being followed.

(7) Admission and eligibility policies are not being adhered to.

(8) Cost to treat patient is too high.

b. AUDIT GUIDES

(1) Determine types of outpatient programs provided by the facility. A large NP hospital will have mental hygiene clinic, day hospital and day treatment programs as well as other specialized programs.

(2) Evaluate efforts to identify and outplace eligible psychiatric patients with resulting reductions in inpatient treatment costs. This should include evaluation of coordination between physicians, nurses and social workers to identify eligible patients and locate outside accommodations.

(3) Test, through review of patient files and discussions with physicians, nurses and social workers, a sample of cases to identify patients eligible for outplacement without restriction. Expand the sample if a high ratio indicated.

(4) Determine the extent to alternative outplacement programs and/or potential therefor, such as use of voluntary agencies and local public/private facilities (town halls, VFW/Legion Posts) for satellite programs that can assist in outplacement of eligible patients.

3. MENTAL HYGIENE

a. Determine if treatment eligibility is being checked.

b. Determine if basic staffing criteria is being met; i.e., is unit comprised of psychiatrist/psychologist and social worker with appropriate supportive services. Are clinics over/understaffed compared to patient activity (clinic stops).

c. Are program goals and objectives established; are they being monitored? Are goals being met?

d. The overall feedback of Mental Hygiene Clinics is to provide support to a patient after his hospital discharge or to avoid hospitalization by treatment on an outpatient basis.

Neurology Service

(6) Determine what replacement equipment has been approved for the Service. Evaluate the Service's justification for the replacement. Be especially alert for equipment being replaced before its planned replacement date. (Conversely, keep in mind that simply exceeding the replacement date alone is not adequate justification for replacement.) If the equipment is being replaced because it is inoperable or too costly to maintain, examine maintenance records for verification. If a piece of equipment is being replaced because it no longer meets the needs of the Service or is not state-of-the-art, determine what additional capabilities the replacement will have. Just as for an additional piece of equipment, evaluate the need for and cost effectiveness of these added capabilities on the basis of workload, identified needs and alternatives.

(7) Since it is administratively easier to replace a piece of equipment than to acquire additional equipment, some services may seek to acquire additional equipment under the guise of replacement. The auditor should ensure that equipment is replaced with comparable items. Also, unused and "junk" equipment should be turned-in to avoid having it used for this type of replacement.

4. QUALITY ASSURANCE REVIEWS. The VA and external accrediting agencies require the continued review of professional activities to ensure the highest level of patient care. While the auditor cannot evaluate the adequacy of professional activities and judgments, it is possible to ensure that the administrative requirements of these reviews are being met and that management has established appropriate internal controls to ensure the quality of patient care.

a. POTENTIAL PROBLEMS

(1) Medical records are not being maintained in accordance with VA and JCAH requirements.

(2) In an affiliated environment, staff physicians may not be adequately documenting the supervision of residents and students.

(3) Consultations may not be completed timely causing increased lengths of stay.

(4) Utilization reviews may not be done or may not be effectively used to control lengths of stay or unnecessary excessive treatment.

(5) Quality assurance reviews and audits may not be done in accordance with VA or JCAH requirements.

b. AUDIT GUIDES

(1) Obtain and become familiar with Joint Commission on Accreditation of Hospitals (JCAH) and VA standards for medical record documentation. Determine if the Neurology Service is complying with these directives. Review facility and Service policies and procedures (including applicable board and committee meeting notes) and analyze the minutes for indications of problems in medical record documentation. If problems are indicated in the minutes, determine the adequacy of action taken by Neurology Service to correct the problems. Determine if quantitative/qualitative reviews of medical records are performed. If deficiencies are noted during the reviews, determine if there is an effective system for followup and correction of deficiencies. Evaluate compliance with JCAH and VA requirements by reviewing a sampling of active patients' medical records in Neurology Service.

(2) Obtain and become familiar with VA regulations, policies and procedures regarding supervision of residents and students. Review local policy and determine if Neurology Service is complying with these directives. Evaluate Neurology Service records pertaining to supervision of residents and students and determine if the degree of supervision meets VA requirements. Determine if work schedules have been established and if they are followed. Of particular importance is whether VA gets what it pays for: (1) when residents rotate out, and (2) when educational details are used (1/6th rule). Determine how supervision is provided during holidays, weekends and at night.

(3) Review and evaluate local policy regarding timeliness of consultations. Determine if delays in completion of consultations have significantly lengthened inpatient stays in the hospital. Select a representative sampling of recently completed consultations and determine the amount of time between the date the consultation was requested and the date it was completed. Analyze the information gathered from the sampling and determine what impact waiting time for consultations had on patients' lengths of stay.

(4) Evaluate the effectiveness of Neurology Service participation in the utilization review function. Determine if Neurology Service participates in the facility utilization review plan to ensure review of justification for admission to the hospital and if admission criteria are documented. Determine if length of stay is routinely reviewed and if criteria and norms are documented. Determine if Neurology Service monitors utilization of laboratory, radiology and nuclear medicine resources by hours, staff and medical students and other medical staff to ensure appropriate utilization. Determine if consultations and special diagnostic techniques are monitored for under and overutilization.

Select three major deficiencies cited in utilization reviews and determine if and how corrective action was taken.

(5) Determine if Health Services Review Organization (HSRO) reviews are done in accordance with Agency policy and local policy.

(6) Review reports and committee meeting notes generated under the HSRO program. Evaluate the content of HSRO reports and committee meeting notes. Determine if findings, conclusions and recommendations result in corrective action. Select a representative sampling of HSRO recommendations and determine if appropriate action was taken to correct deficiencies.

5. PROFESSIONAL SERVICE SUBSPECIALTIES PROGRAMS/CLINICAL. Neurology Service may accomplish its mission through the use of clinical subspecialties. These subspecialties may or may not be specifically identified as organizational sections of the Service. Some subspecialties may be provided as a part of the medical center affiliation, may be purchased as needed from the local community, or may be provided by outside consultants. Professional service programs are clinical subspecialties or functions which were specially funded and for which program officials in VACO have certain responsibilities. Specific productivity and utilization standards may be associated with these programs. The established standards should be used as guidelines in assessing productivity and utilization.

a. POTENTIAL PROBLEMS

(1) Inaccurate or undocumented workload reporting can result in unrealistic workload projections, underutilized resources or inappropriate plans to initiate or expand a professional service.

(2) The facility may be providing a specialized service which could be acquired at less cost through sharing.

(3) The Service may be purchasing specialized services which could be provided more cost effectively by facility personnel.

(4) Controls may not be implemented to ensure that the facility is receiving all of the services it is paying for.

(5) The facility may not be charging for all of the services it provides.

Radiology Service

(3) Staff may fail to obtain or document informed patient consent as required before conducting certain procedures. Reports/records of treatment/diagnosis may not be properly completed or may not be filed in patient medical records.

b. AUDIT GUIDES

(1) Evaluate the overall quality and timeliness of services provided by Radiology Service. Interview both Radiology Service staff and staff from other services to ascertain their evaluation of quality and timeliness of Radiology Service's services. Determine whether local standards are established (in addition to those which may be established by Central Office) for the quality and timeliness of work. Conduct tests to determine the timeliness of work by measuring turnaround time from request to finished product and actual staff time used to accomplish work (should be within 24 hours for most procedures). Evaluate patient scheduling. Is there a problem with no shows or cancellations? Is overscheduling used? How many examining rooms are there, and what is each used for? By observation, interview and examination of records, determine if there are periods of high demand contrasted by periods with little activity. If so, why? Could the work be scheduled more evenly? Do employee tour of duty schedules contribute to efficient service operations? What quality and productivity standards are established? How are staff quality and productivity measured? Are there quality reviews? How often must procedures be repeated because of technician error (which technicians/what action is taken)? Determine if there are work backlogs and why. How many x-rays are awaiting interpretation by radiologist? How long will it take the radiologist to read them? How many dictated x-ray reports are awaiting typing? How long will it take to type them?

(2) Evaluate adequacy of controls over x-ray films and patient records. Through interview and observation, determine if there is a backlog of unfiled reports or patient records. How are films and patient records controlled both during normal duty hours and at night or during the weekends? Place particular emphasis on evaluating controls of films and records obtained/retained by residents and house staff. Examine a sample of patient records to determine if films for all procedures accomplished within the past 2 years are present. The assistance of radiologists or technicians may be required.

(3) Evaluate Radiology Service's procedures for ensuring informed patient consent is obtained and documented in patient records as required. Generally, procedures in which a substance is introduced into the patient's body, for example, a dye or radioactive fluid, require informed consent before the procedure is conducted. Examine a sample of records associated with patients who have received procedures requiring informed consent for

appropriate documentation of such consent. Verify that reports for all procedures conducted are filed in patient medical records. Deficiencies involving lack of patient consent and proper documentation of treatment/diagnosis could result in legal problems. Determine if complaints from patients or physicians have been received or if lawsuits have been filed. Determine disposition of complaints/lawsuits and evaluate action taken.

3. SAFETY. This guide area addresses the adequacy of medical, mechanical, electrical, fire and radiation safety policies and procedures. The auditor should review the minutes of the facility Safety Committee, Infection Control Committee, available Radiology Service documents relating to safety and facility fire and safety regulations. Review also the U.S. Nuclear Regulatory Commission's (NRC) Rules and Regulations, pt. 20, par. 20.101, which establish lifetime radiation levels for individuals.

a. POTENTIAL PROBLEMS

(1) Radiology Service's policy and/or ability to handle medical emergencies is inadequate.

(2) Calibration and maintenance of x-ray equipment is deficient. Unqualified persons are allowed to operate or repair equipment.

(3) Radiology Service fails to comply with safety and fire regulations contained in Service and facility policy.

(4) Procedures and controls to protect patients and staff from excessive radiation are inadequate.

b. AUDIT GUIDES

(1) Evaluate Radiology Service's medical emergency program. Ensure emergency carts containing sufficient quantities of emergency medical drugs and equipment are placed and properly maintained in Radiology Service. Determine if the policy for maintaining emergency carts is current and that staff understand policy for handling medical emergencies which includes provisions for (1) informing the patient's physician, (2) informing Radiology staff and management, (3) directing the emergency team, and (4) accessing emergency equipment.

(2) Evaluate Radiology Service's maintenance program. Review local policies and operation/maintenance instructions published by equipment manufacturers. Determine whether there is routine maintenance of x-ray equipment by qualified medical repair personnel, with results recorded, and follow-up for deficiencies

Dental Service

(3) Required maintenance and safety checks may not be done.

(4) Equipment may become obsolete, due only to professional preferences.

b. AUDIT GUIDES

(1) Determine that physical inventories have been reconciled with the Service's CMR's within the past 12 months and have been certified by the Service Chief.

(2) Determine if equipment items on loan are appropriately documented.

(3) Check that equipment contains preventive maintenance inspection (PMI) tags and safety inspection tags when appropriate.

(4) Review Service storage areas for any equipment which appears unused. Determine the reasons for the lack of use and the Service's plans for the equipment.

4. QUALITY ASSURANCE REVIEWS. The VA and external accrediting agencies require the continued review of professional activities to ensure the highest level of patient care. While the auditor cannot evaluate the adequacy of professional activities and judgments, it is possible to ensure that the administrative requirements of these reviews are being met and that management has established appropriate internal controls to ensure the quality of patient care. Each Chief, Dental Service, is responsible for establishing and maintaining written policy and procedures for radiology quality assurance.

a. POTENTIAL PROBLEMS

(1) In an affiliated environment, staff physicians may not be adequately documenting the supervision of residents and students.

(2) Utilization reviews may not be done or may not be effectively used to control unnecessary treatment.

(3) Quality assurance reviews and audits may not be done in accordance with Agency or JCAH requirements.

(4) A monitoring program of dental radiology may not be established to confirm minimum exposure to patient and operator.

b. AUDIT GUIDES

(1) Review local policy regarding supervision of residents and students, and determine if the degree of supervision meets VA requirements. Determine how supervision is provided during holidays, weekends and at night.

(2) Evaluate the effectiveness of Dental Service participation in the utilization review function. Determine if consultants and special diagnostic techniques are monitored for under and overutilization. Select three major deficiencies cited in recent utilization reviews and determine if and how corrective action was taken.

(3) Review and determine if Health Service Review Organization (HSRO) findings, conclusions and recommendations have resulted in corrective action. Select a sample of HSRO recommendations and determine if appropriate action was taken to correct deficiencies.

(4) Review written policies and procedures. Determine if the station's radiological safety officer has assured that radiation protection surveys are conducted.

5. INTERNAL CONTROLS. Emergency dental treatment for VA employees may be provided to the extent necessary to permit employees to remain on duty. The Chief, Dental Service, is responsible for the safekeeping of precious metals but may assign a staff member to administer the control of precious metals. All precious metals such as gold, platinum or silver must be accounted for. Safeguards should also be in place to prevent mercury contamination and for protection of unnecessary exposure to radiation.

a. POTENTIAL PROBLEMS

(1) Employees may be receiving unauthorized dental treatment.

(2) Control over the safekeeping of gold, platinum and silver may not be adequate.

(3) Guidelines for safe handling and control over mercury and amalgam could encourage unsafe practices.

(4) Written policies and procedures to protect patients and employees from the harmful effects of unnecessary exposure to radiation may be inadequate or nonexistent.

Nursing Service

workload in recent years, determine if there has been a corresponding reduction in staffing. If not, determine the reason.

(4) Review Nursing Service policy and procedures for overtime. Is it approved routinely? Are there adequate controls?

(5) Determine the accuracy of Nursing Service workload statistics, such as bed occupancy, admissions, and discharges that are reported to facility management and to Central Office. Interview personnel who collect the data. Determine if they are accurately reporting the workload. Review any logs or worksheets on wards or inpatient treatment areas to see if they correspond with reported workload.

(6) Review facility policy concerning patient abuse and medication errors. Alleged incidents of patient abuse and medications are usually reported to management using VA Form 10-2633 (Report of Special Incidents Involving a Beneficiary). Review to determine if any trends develop regarding patient abuse and medication regarding Nursing Service.

(7) Review space assignments of functions within Nursing Service. Determine if space for offices, training and education, and conference rooms are conveniently located for the patients and employees who use it. Determine if there are any construction or renovation plans which could be avoided by more effective allocation of existing space.

(8) Review the administrative and clerical positions in the Service. Determine what duties they perform and ascertain the amount of time required to complete these tasks. Check position descriptions to see if they contain appropriate duties and reflect the tasks that are actually being performed. Determine if administrative assistants are performing tasks which should be done by the service chief. Assess the need for the current level of clerical and administrative staffing.

3. QUALITY ASSURANCE REVIEWS. The VA and external accrediting agencies require the continued review of professional activities to insure the highest level of patient care. While the auditor cannot evaluate the adequacy of professional activities and judgments, it is possible to insure that the administrative requirements of these reviews are being met and that management has established appropriate internal controls to insure the quality of patient care.

a. POTENTIAL PROBLEMS

(1) Medical records are not being maintained in accordance with Agency and JCAH requirements.

(2) Utilization reviews may not be done or may not be effective.

(3) Quality assurance reviews and audits may not be done in accordance with Agency or JCAH requirements.

b. AUDIT GUIDES

(1) Obtain and become familiar with Joint Commission on Accreditation of Hospitals (JCAH) and VA standards for medical record documentation. Determine if the Nursing Service is complying with these directives. Review facility and Service policies and procedures (including applicable board and committee meeting notes) and analyze the minutes for indications of problems in medical record documentation. If problems are indicated in the minutes, determine the adequacy of action taken by Medical Service to correct the problems. Determine if quantitative/qualitative review of medical records are performed. If deficiencies are noted during the reviews, determine if there is an effective system for followup and correction of deficiencies. Evaluate compliance with JCAH and VA requirements by reviewing a sampling of active patients' medical records in Nursing Service.

(2) Evaluate the effectiveness of Nursing Service participation in the utilization review function. Select three major deficiencies cited in utilization reviews and determine if and how corrective action was taken.

(3) Determine if Health Services Review Organization (HSRO) reviews are done in accordance with agency policy. Review reports and committee meeting notes generated under the HSRO program. Evaluate the content of HSRO reports and committee meeting notes. Determine if findings, conclusions and recommendations result in corrective action. Select a representative sampling of HSRO recommendations and determine if appropriate action was taken to correct deficiencies.

(4) FINANCIAL ACTIVITY. Fund control may be established at the Service or section level depending on the size of the facility. Major sections may have separate fund control points and a significant impact on the Service's budget planning. Nursing Service is also responsible for inputting to the "Report of Medical Care Distribution Accounts" (RCS 14-4) the cost of its activities in selected professional services and the support of other functions at the facility such as outpatient treatment. Nursing Service should review the RCS 14-4 to ensure that it accurately reflects the cost of Nursing Service programs. This is especially important when these costs are used in determining facility charges for the Service under sharing agreement.

Nuclear Medicine Service

a. POTENTIAL PROBLEMS

(1) Lack of appropriate storage area.

(2) Inappropriate receipting procedures.

(3) Ineffective monitoring of supplies on hand resulting in excess purchases and unnecessary use of space.

b. AUDIT GUIDES

(1) Evaluate the station policy concerning the storage and handling of radioactive materials. Determine if the station policy is in compliance with the NRC requirements. Tour the Service and ask to see where any radioactive material is stored. Determine if the storage area conforms with NRC requirements. Determine who has access to the storage area. Determine if other supplies are stored with radioactive materials.

(2) Determine how supplies are ordered. Determine if the individual ordering supplies has knowledge of supplies on hand. Check the storage room and determine if there appears to be a significant amount of supplies on hand. Review outstanding purchase orders (VAF 10-2237's) or the control point [illegible] book to see if supplies are routinely ordered without checking the available supplies.

(3) Determine who has the authority for receipting for supplies. How soon are supplies stored after receipt? If supplies are received by other services (i.e., Supply or Radiology), how is Nuclear Medicine Service notified? Also, do these other services have adequate storage facilities until the supplies can be delivered/picked up by Nuclear Medicine Service.

5. QUALITY ASSURANCE REVIEWS. The VA and external accrediting agencies require the continued review of professional activities to ensure the highest level of patient care. While the auditor cannot evaluate the adequacy of professional activities and judgments, it is possible to ensure that the administrative requirements of these reviews are being met and that management has established appropriate internal controls to ensure monitoring of the quality of patient care as well as the efficiency and effectiveness of operations.

a. POTENTIAL PROBLEMS

(1) Quality assurance systems are not in place to ensure compliance with requirements of accrediting bodies.

(2) Repeat JCAH-related deficiencies are being identified in JCAH surveys.

(3) In an affiliated environment, staff physicians may not be adequately documenting the supervision of residents and students.

(4) Consultations may not be completed timely causing increased lengths of stay.

(5) Service internal reviews may not be done or may not be acted upon.

(6) Quality assurance reviews and audits may not be done in accordance with Agency or JCAH requirements.

b. AUDIT GUIDES

(1) Determine if Nuclear Medicine Service has systems (internal controls or processes) in place that ensure compliance with JCAH standards for direction/staffing, space and equipment, policy development/enforcement, clinical and administrative documentation, and quality/appropriateness of care reviews.

(2) Determine if JCAH deficiencies relating to Nuclear Medicine Service identified in the most recent JCAH survey were also cited in the previous JCAH survey. Determine the reason for repeat deficiencies and if internal controls are established to plan corrective action and monitor implementation of corrective action.

(3) Obtain and become familiar with VA regulations, policies and procedures regarding supervision of residents and students. Review local policy and determine if Nuclear Medicine Service is complying with these directives. Evaluate Nuclear Medicine Service records pertaining to supervision of residents and students and determine if the degree of supervision meets VA requirements. Determine if work schedules have been established and if they are followed. Determine how supervision is provided during holidays, weekends and at night.

(4) Review and evaluate local policy regarding timeliness of consultations. Determine if delays in completion of consults have significantly lengthened inpatients' stay in the hospital. Select a representative sampling of recently completed consultations and determine the amount of time between the date the consultation was requested and the date it was completed. Analyze the information gathered from the sampling and determine what impact waiting time for consultations had on patients' length of stay.

(5) Evaluate the effectiveness of Nuclear Medicine Service participation in the Health Services Review Organization (HSRO). Determine if HSRO reviews are done in accordance with Agency policy. Review reports and committee meeting notes generated from the HSRO program. Evaluate the content of HSRO reports and committee meeting notes. Determine if findings, conclusions and recommendations result in corrective action. Select a representative sampling of HSRO recommendations and determine if appropriate action was taken to correct deficiencies. Determine if Nuclear Medicine Service monitors utilization of nuclear medicine resources by house staff and medical students and other medical staff to ensure appropriate utilization. Determine if consultations and special diagnostic techniques are monitored for under and overutilization.

6. SAFETY. This guide area addresses the adequacy of medical, mechanical, electrical, fire and radiation safety policies and procedures. Equipment used for direct patient care is subject to stringent maintenance and safety requirements. The auditor should review Agency maintenance requirements, minutes of the facility Safety Committee, Infection Control Committee, available Nuclear Medicine Service documents relating to safety and facility fire and safety regulations. Also review the U.S. NRC's Rules and Regulations, Pt. 20, Par. 20.101, which establish lifetime radiation tolerance levels for individuals.

a. POTENTIAL PROBLEMS

(1) Nuclear Medicine Service's policy and/or ability to handle medical emergencies is inadequate.

(2) Calibration and maintenance of equipment is deficient.

(3) Unqualified persons are allowed to operate or repair equipment.

(4) Radiation substances are not prepared, stored or disposed or properly.

(5) Nuclear Medicine Service fails to comply with safety and fire regulations contained in Service and facility policy.

(6) Procedures and controls to protect patients and staff from excessive radiation are inadequate.

b. AUDIT GUIDES

(1) Evaluate Nuclear Medicine Service's medical emergency program. Ensure emergency carts containing sufficient quantities of emergency medical drugs and equipment are placed and properly

Recreation Service

(5) Review the Systematic Internal Reviews (SIR's). Determine that the SIR's meet the facility's Quality Assurance requirements and that problems are identified and corrective action is taken. Evaluate other Service reviews, such as patient medical record reviews, program audits, and peer audits. Evaluate the Service's participation in multidisciplinary teams.

(6) Select a recent segment of the Recreation Service AMIS Report, RCS 10-300, and validate the data.

(7) Determine the extent of the activities provided. Examples of the different activities are listed within DM&S Recreation Service Guidelines for VA Nursing Home Care Units and Contract Nursing Homes, M-1, Part IX, G-1; Recreation Service Guidelines for Domiciliaries, M-1, Part IX, G-2; and Recreation Service Guidelines for the Spinal Cord Injured, M-1, Part IX, G-3. Evaluate whether these programs make full use of Recreation Service resources.

(8) Evaluate the Service's program for use of volunteers and determine whether these procedures comply with M-2, Part XVII, Chapter 3.

(9) Evaluate staff development programs.

(10) Evaluate scheduling of Service activities.

2. RECREATION THERAPY SECTIONS(S). The recreation therapists are responsible for completing initial assessments upon receipt of referrals, for determining treatments, and for monitoring treatment.

a. POTENTIAL PROBLEMS

(1) Referrals are not completed timely as required by local station policy.

(2) Documentation in patient medical records is incomplete. Patient assessments, treatment plans, and progress notes are not always entered or are entered too infrequently for effective monitoring of treatment.

b. AUDIT GUIDES

(1) Evaluate timeliness of completed referrals.

(2) Evaluate medical record documentation regarding patient assessments, treatment plans, and progress notes.

(3) Determine whether recreation therapist participation in group therapy or multidisciplinary teams is considered effective by other clinical services.